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Preface

The 87th Annual Forum of the National Conference on Social Welfare, held in Atlantic City, June 5–10, 1960, yielded an unusually large number of papers of importance and significance. In order that as many of these papers as possible might be made available for study, the various editorial committees decided to publish five special volumes in addition to the official proceedings. The volumes to be published are: *The Social Welfare Forum 1960* (the official proceedings), *Mental Health and Social Welfare, Community Organization, Social Welfare Administration* (all four by Columbia University Press); *Social Work with Groups* (National Association of Social Workers), and this volume of casework papers.

In selecting the papers for inclusion in *Casework Papers 1960,* the committee gave preference to those that reflected the Conference theme, "The 60's—Social Welfare Responds to a New Era." In general, the papers selected are focused on broad issues rather than on the minutiae of techniques. In some instances, the authors strike a critical note, asking searching questions about traditional social work methods. New approaches are suggested for dealing with such serious social problems as delinquency, unmarried parenthood, alcoholism, and other forms of acting-out behavior. In fact, the emphasis in this volume is on the group of individuals and families whose behavior creates considerable public concern but whose problems have not received adequate professional attention. The committee believes that the predominance of papers dealing with delinquent and asocial individuals is indicative of an awakening sense of responsibility, on the part of social workers, for this neglected group of troubled persons.

The papers in this volume also point to social work's increasing activity in the area of research. The committee believes that *Casework Papers 1960,* the seventh volume in this series, highlights the major current concerns of social work and points directions for new efforts in the decade ahead. It is interesting to note the extent to which these annual volumes throw the spotlight on the prevailing social work concerns of the day.

The committee wishes to express its appreciation to Cora Kasius, Director of FSAA Publications Service, and to Joe R. Hoffer and Eula B. Wyatt of the conference staff, who served as ex-officio members and helped in many ways to facilitate its work. The points of view expressed in the papers do not necessarily represent those of the editorial committee or the National Conference. The Conference is an open forum and the authors speak only for themselves.

WAYNE VASEY, *Chairman*
SUSAN T. PETTISS
Selection Committee for Casework Papers, 1960
National Conference on Social Welfare

October 25, 1960

UNDERSTANDING THE DYNAMICS OF PARENTS WITH CHARACTER DISORDERS

Irving Kaufman, M.D.

THE TERM "CHARACTER DISORDER" is used in a variety of ways. It is used popularly to characterize someone who lacks character, goal, or purpose. The term is also used to describe clinical concepts related to personality manifestations in the classical psychoneuroses and psychoses. For a discussion of the full range of clinical meanings of the term the reader is referred to Fenichel.[1] In his view, the personality structure of hysterical or obsessive characters, or of schizoid characters, is the same as that of persons who develop neuroses or psychoses but their disturbance is marked by an absence of phobias, obsessive rituals, or other overt symptoms.

This paper will actually be more closely related to the first concept than to the second, since the focus will be on those clients who, in the eyes of the public, "lack character." Without making value judgments about these sick people, let us consider who they are, how they differ from other diagnostic groups, how they function, and what effects they have on their children. It is important to understand the personality structure of these persons if we are to plan effective treatment. Diagnostically, these individuals—whose personality problems include the need to stimulate negative reactions in others—fall in the category of "impulse-ridden character disorders." [2]

[1] Otto Fenichel, M.D., *The Psychoanalytic Theory of Neurosis,* W. W. Norton & Company, New York, 1945, pp. 463–540.

[2] Beatrice Simcox Reiner and Irving Kaufman, M.D., *Character Disorders in Parents of Delinquents,* Family Service Association of America, New York, 1959.

The person with this type of disturbance is characterized by several rather specific features. He handles stress by manifesting some form of behavioral reaction, rather than a clinical symptom. The classical schizophrenic, in contrast, handles stress by regression, psychotic delusions, or hallucinations, while the neurotic handles it by the symbolic symptom formation of a phobia, a conversion hysteria, or an obsessive compulsive neurosis. Also, the person with a character disorder does not utilize psychosomatic reactions. His behavioral reaction to stress is characterized by conflict with the laws, mores, or customs of the culture. The dynamic meaning of the symptom pattern of persons suffering from neuroses, psychoses, or psychosomatic disorders is different from that of persons with character disorders since, in the former, it represents a pathologic conflict between two parts of the self. The schizophrenic hears a voice that emanates from himself and the person with a psychosomatic disorder expresses his inner conflict in some part of his body.

The person with a character disorder, whose symptom may be stealing, promiscuity, illegitimate pregnancy, vandalism, and so forth, is not involved in an inner conflict but in emotionally-laden interaction between himself and someone or something outside himself. The dynamic meaning of the interaction between the self and the environment is that it expresses a special form of conflict. The process of expressing conflict, however, parallels that utilized by the schizophrenic when he distorts ideas, or by the neurotic when he develops psychosomatic disorders. In other words, the pathologic interaction between the self and the environment by the person with a character disorder also expresses a conflict between two parts of the self, in the sense that the environment represents a projection of a part of himself.

The concept of conflict has important treatment implications. In the treatment of any emotional disorder, it is necessary to understand not only the nature of the conflict and the mechanisms of defense utilized by the ego, but the arena in which the conflict is expressed. For example, if an individual's conflict is expressed in a hysterical paralysis of his arm, one does not expect the etiology to reside in the arm. By the same token, a conflict occurring in the environment does not necessarily mean that it was caused by the environment; the person may only be utilizing that arena for the

expression of his conflict. In treating the person with a character disorder, therefore, one must understand the nature of the conflict between the self and that part of the self projected onto the environment, as well as the definitive factors related to the etiology of the conflict. The goal of all therapy is to modify the conflict in order that the individual will not need to continue his pathologic pattern.

Because these clients express their symptoms in the environment, and because they need to create an interaction that is characterized by attack and retaliation, large segments of our society unfortunately seem quite willing to become involved in efforts to punish them or treat them as criminals. Welfare legislation is enacted that discriminates against parents who manifest asocial behavior. These parents are granted only minimal subsistence allowances, they usually must live in the worst housing in the community, and their children must attend the poorest schools. The doors of many social agencies, too, are closed to them, since these persons are classified as untreatable because they do not show proper motivation.

What is the psychodynamic meaning of the paradox implicit in negative attitudes of social agencies toward this group of clients with the greatest need? These clients, who constitute a large segment of the caseload of most social agencies, make inordinate demands which arouse conflicted and sometimes hostile reactions in the staff members and officials of social institutions. These negative reactions, I believe, stem from the fact that there has been no agreement about diagnosis, etiology, or treatment. This phenomenon—of multiple, contradictory, and confused concepts about treatment—is a familiar one in medical history; it appears when there is confusion about the basic etiology of a disease. For example, before the tuberculosis bacillus was discovered, research of the associative type was in vogue. Tuberculosis was found to be positively associated with poor housing, poor sanitation, low economic status and certain ethnic groups, such as Negroes and the Irish, and negatively associated with the Jewish group. Physicians thought of tuberculosis as a disease of the lower classes, and took refuge in "the exception to the rule" type of reasoning to explain the existence of the disease in the middle and upper classes.

There is a striking parallel between this type of associative medical research and the current research on adults with character

disorder and their delinquent children. Medical science now approaches the problem of tuberculosis by searching for a drug or vaccine to eliminate the tubercle bacillus. In an analogous way, we must come to some agreement about the clinical etiology of character disorders, and not continue to ascribe such pathology to class level, ethnic group, and so forth. The part that these social and cultural factors play in contributing to the poor adjustment of these persons must, of course, be recognized, but these factors should be separated from the fundamental psychological factors. If there were greater agreement about etiology, the numerous social agencies would have a unifying base for operation, which would result in less fragmentation of services. Instead of child placement, child guidance, or probation, agencies would be able to provide a family-oriented type of therapy that would take into account the multiple needs and problems of these families.

Unfortunately, personality problems do not follow a clear-cut etiologic pattern, so we cannot hope to discover a delinquency bacillus or a character disorder bacillus. The analogy to medical science, however, does have some usefulness. Once it is agreed that we are dealing with a psychological entity, then we can pursue study along these lines. The approach to the study of character disorders should be the same as that which is being used to delineate other major psychological syndromes. Definitive diagnoses, in both the medical and psychological fields, point the way to precise treatment techniques. Now that physicians know that a certain type of pneumonia is caused by the pneumococcus which is affected by penicillin, a diagnosis of pneumococcal pneumonia, obviously, points to the advisability of giving penicillin as quickly as possible.

Differential Diagnosis

Since we do not have such specific factors as bacteria on which to base diagnoses of emotional disorder, we must rely instead on the presence or absence of a certain cluster of personality characteristics. For example, in conversion hysteria, the conflict is at the oedipal-phallic-urethral level of development, with its associated castration anxiety. The ego mechanisms that seem to predominate are those of repression, displacement, and conversion. The unconscious oedipal conflict is repressed; it returns to consciousness,

but then is displaced onto some body part and converted into a somatic reaction. The person's object relations are relatively advanced and include a differentiation of the mother, father, and child, and the feelings associated with the classical triangular conflict.

Similar diagnostic criteria could be outlined for psychoses, psychosomatic reactions, and so forth. For each syndrome, the diagnosis is based on a four-fold cluster: (1) the level of instinctual development; (2) the kind of anxiety; (3) the presence of a certain group of defense mechanisms; and (4) a specific type of object relationship.

If we consider the impulse-ridden character disorder as a definitive clinical entity, it is necessary to apply diagnostic criteria with the same strictness as is done with any other emotional syndrome. We found in our research study [3] that it was possible to delineate the diagnosis of this disorder by applying the four-point cluster listed above. In fact, we believe that the impulse-ridden character disorder fills in a missing link in the diagnostic sequence. It falls between the psychoses and neuroses.

If we look at the diagnostic sequence—schizophrenia, impulse-ridden character disorder, and psychoneurosis—we find parallels between the features of normal personality development and features of the syndromes. For example, in schizophrenia the pathology parallels the most primitive stages of personality development; the conflict is at a deep oral level and the anxiety is associated with the fear of total annihilation, not simply castration. The anxiety is expressed by these patients in terms of world destruction fantasies. Their defense mechanisms are those of regression, projection, and distortion of reality. Their object relationships are on the most primitive mother-child, oral-symbiotic level.

The features of a conversion neurosis were mentioned earlier. This conflict centers around the love for the parent of the opposite sex and the hate for the parent of the same sex. The individual's fears have advanced beyond that of annihilation and are limited to the genital zone; his castration anxiety is expressed in terms of who "has more" or "is better." His object relationships are at the oedipal level, which means he differentiates between people. His ego mechanisms are primarily those of repression, displacement, and conversion.

[3] Beatrice Simcox Reiner and Irving Kaufman, M.D., *op. cit.*

The person with a character disorder has reached a point in personality development somewhere between that of the person with a psychosis and one with a neurosis. Developmentally, he is at the stage of the child who can feed himself, who is partly toilet trained, and who knows his parent is there but, after playing a while, wanders back to the kitchen to make sure. A child at this stage of development has some security in his relationships, but it is not at the level of the 5- or 6-year-old child who has reached the oedipal stage and can begin to go off to school all day and have energy available for learning. The anxiety of persons with character disorders is mainly related to separation. They have not advanced to the genital level of the neurotic, nor are they so regressed that they expect to fall apart, as does the psychotic.

Like the 2- to 5-year-old child, these persons have boundless energy and, in many instances, the same kind of charm. At times, their energy is used constructively, but under stress it tends to be used destructively. Like children who knock down their building blocks, these people ruin their job situations, break their relationships with others, run away, get drunk, are promiscuous, and so forth. They have strong instinctual energy but have not developed a sufficiently strong ego or superego to make them capable of prolonged goal-directed activity or to take adversity in their stride. In their psychosexual development they have not made the normal developmental step of synchronizing the components of instinctual energy—the oral, anal, visual, tactile, and so forth—into heterosexual relations or of sublimating them into learning and creativity. Instead, these adults when under stress behave like young children —peeping, striking out, hurting, getting hurt, stealing, and grabbing.

The goal of treatment is to help these impulse-ridden people reach a higher level of development—to "grow up" and take greater responsibility for their actions. However, if the person who undertakes to help them makes demands that seem unreasonable to them, they are likely to run away from treatment. Demands that are too heavy for their capacities add to their stress and their feelings of frustration, and serve only to perpetuate or exacerbate their problems.

Anyone who observes a child of nursery-school age is struck by his activity and busyness. For instance, after a child has been to a

doctor, he may spend many of the following days inoculating his teddy bear. He constantly re-enacts the daily activities of family members, such as going off to work, cooking a meal, shopping, and so forth. By re-enacting the pleasant and frightening aspects of his life, the child is endeavoring to gain emotional mastery. In an analogous way, these impulse-ridden parents resort to busyness and activity to handle stress. Their ego mechanisms are similar to those of the nursery-school child. If they want something, they take it, and the fact that it belongs to someone else is of little concern to them. As Freud has pointed out, the superego and its associated conscience does not develop until there has been a resolution of the oedipal conflict.[4] This phase of development does not occur until after the age of six.

The adults with character disorders continue the pattern of childhood of handling stress by the mechanism of repetition compulsion. Like the child inoculating his teddy bear, these adults act out their tensions. They repeatedly steal or run away or act out sexually. When we carefully observe this behavior and gradually come to understand its meaning, it is clear that these people are re-enacting the trauma of the loss in early life of a meaningful object relationship. In their backgrounds, there is a history of broken homes, separation and divorce of parents, and the absence of parental care as a result of real or emotional abandonment. These traumas leave an imprint on the personality which may be described as a "depressive nucleus." As adults they act as a young child does who has suffered a loss. They do not express sadness or grief, but they handle these feelings by activity, isolation, denial, projection, and primarily the mechanism of repetition compulsion.

These ego mechanisms for dealing with stress encompass those characteristic of the oral, anal, and, to some extent, the phallic-urethral levels of instinctual development, that is, all the pre-oedipal levels. The fixation at any one level may have various meanings and be handled by different mechanisms, which are determined by the degree of ego development. For example, one individual with an oral fixation may operate at the primitive ego level of the schizophrenic; this oral phenomenon is quite different from that

[4] Sigmund Freud, *The Ego and the Id.* The Hogarth Press, Ltd., London, 1927. Chapter III.

of the neurotic who overeats. Persons with character disorders draw on all the instinctual phenomena of the oral, anal, and phallic-urethral stages of development to serve the ego's need to cope with object loss and sense of deprivation.

The nature of the object relationships of persons in this group have different characteristics than those of the schizophrenic and the neurotic. In the schizophrenic, we find a symbiotic, all-encompassing relationship that represents the deepest oral level of development. He is able to make little differentiation between parent and child, or to recognize their separate entities. Their ego boundaries are minimally established. The neurotic is able to differentiate clearly between mother, father, and child, and has considerable awareness of interaction between them. The person who is suffering from a character disorder falls midway between the schizophrenic and the neurotic. He has not made the clear differentiation between himself and others that the neurotic has achieved, but he is not so undifferentiated as the schizophrenic. As was indicated earlier, he is like the child who can wander away from his mother for a short distance but must return quickly to make certain that she is really there. He has made a partial object differentiation, but he still invests the parent-child interaction with considerable magic, and he is especially fearful of the loss of parental protection.

Effects on Children

The personality patterns of parents with character disorders have serious effects on their children, frequently producing delinquency. The children often develop a similar personality structure which leads to the same kinds of problems. Because these parents have not matured psychologically, they draw their children into all their conflicts and problems. In their child-rearing practices they are inconsistent, alternating between instinctual indulgence and punitive behavior. Their punitive behavior is more often an expression of their own sense of tension, anger, or frustration than a reaction to a specific action on the part of the child. As a result, the child sets up a pattern of hostility and retaliation as a way of relieving tension and fails to build a conscience through constructive learning experiences. Because of this pattern, it is futile to punish either the parents or the child for their delinquencies. Punishment does

not deter them or teach them a lesson. It often serves the opposite purpose of reinforcing their familiar ways of behaving. When one studies the case records of persons with character disorders who have been committed to prison for the twentieth, or even the fortieth time, one is tempted to ask: Who has failed to learn the lesson? The community, no less than the recidivist, is perpetrating a pattern of crime and punishment. Punishment only serves to maintain the ultimately self-destructive pattern of behavior for the person with a character disorder.

Many of these parents, by their example, teach their children to be antisocial by including them in their own antisocial acts. They also show their approval when a child shows up with a new bicycle or some extra money. Some parents, with similar internal conflicts, may not be overtly delinquent themselves but they may unconsciously encourage delinquent behavior in their children. These parents, because of their old hostilities about their own neglect and abandonment in childhood, act out their resentment by stimulating the child to take what he wants wherever he finds it. Because of their antagonism to authority, which they may not express directly, these parents ignore the child's disobedience to teachers or other authoritative figures. Although they may verbally tell the child not to engage in an antisocial act, they often smile when doing so, revealing their pleasure in such behavior.

An unhealthy parent-child interaction is also created by the deep dependency needs of these adults. They, themselves, are seeking parental care and therefore unconsciously put pressure on their children to meet these needs. Using the nursery school model again, we can imagine these parents almost saying to a child: "This time I will be the baby and you will be the mommy." Such pressure on the child has the effect of pushing him prematurely into a kind of interaction with his environment that makes him worldly-wise and able to fend for himself. The delinquent child, as a result, often appears to be hard and tough but the toughness is his way of concealing underlying, unmet dependency needs.

Despite their external toughness, persons with character disorders are basically frightened and insecure. They reveal their insecurity in their tendency to be rigid and live constricted lives. For example, they often cling to the same neighborhood for several generations.

Caseworkers in protective agencies frequently find, when investigating a complaint against a mother for abuse and neglect of her illegitimate children, that she lives only a few doors away from her own mother and that a similar charge had been made against the latter when the present neglectful mother was a child.

Attempts to place children of these disturbed families, to move a family into better housing, or to find a more suitable job for the breadwinner are not likely to be successful. These attempts fail because the insecurity of these persons forces them to adhere to a relatively limited pattern of living; although they may move from job to job, their movements are within a narrow vocational, and often geographical, range. When these families are mobile, they manage to create a similar pattern of living and working wherever they go. One woman's history showed that she moved from a Boston slum to a Cuban slum, and had the same type of conflict with the authorities in both places. Her old antisocial pattern of behavior continued in her new environment.

Treatment Implications

Although the focus of this paper is on the dynamics of these clients, it might be useful to point to some of the treatment implications, especially to the types of ego defenses that must be understood and handled. As has been indicated, parents with character disorders, as well as their delinquent children, function at a pre-oedipal level of development. One of the objectives of treatment is to help them grow up to the point of developing a conscience, with its associated guilt, to serve as a guide for their life activities. It is my impression that caseworkers, because of their training in the use of relationship therapy, have a great deal to offer this type of client who needs a long-term relationship with a new parental figure. Through the relationship, the client can be helped to develop new attitudes toward his needs.

The techniques for this group of clients, however, are not the same as those used for psychotic or neurotic clients. Persons with character disorders are struggling with the problem of object loss and, as a result, are fearful and suspicious. They are unable, on their own initiative, to take steps to form a relationship. To expect them to take the responsibility for initiating and maintaining a

treatment relationship is equivalent to asking them to cure themselves of their illness before they begin treatment. They need someone who will seek them out and who will not be afraid to use authority in a constructive manner to maintain a treatment relationship. The helping person must understand that handling such daily concerns as the family budget, lack of clothing, poor health, and neglect of teeth are all elements in the dynamic treatment plan. In other words, treatment should be "pitched" at the same level as the developmental level of the client and the ways of communicating with him should be appropriate to this level of development. In contrast, communication with the neurotic client, who operates on a relatively logical basis, can be focused on cause and effect phenomena; with the psychotic client, who operates on the level of primary processes, communication must be in the language of his unconscious.

The client with a character disorder, who is neither neurotic nor psychotic, understands what he can observe at the moment. He has great difficulty in believing that anyone, including the caseworker, will be available when needed. In the early phase of treatment, he will test out repeatedly whether the caseworker will stand by him; he often runs away from the relationship in order to test the worker's interest and concern. If the caseworker permits the client to evade contact, the client is convinced that he has been deserted. As a result, his pathological pattern remains unbroken. This mechanism puts a special burden on the caseworker. Like the parent of the nursery school child, he must decide when to grant freedom of choice and when to deny it. For example, if a 3-year-old child wishes to light a box of matches or cross a busy highway, the parent must take the responsibility for protecting him in these ventures. In an analogous way, the caseworker must take responsibility for deciding what action should be taken when a parent abuses or neglects his children. The caseworker's first effort should be to engage the client in treatment but, if this fails, he must make a judgment about what needs to be done to protect both the parent and the children. Such decisions are not easy to make and one can only have great admiration for the devotion and steadfastness of the caseworkers whose task is to deal, day-in and day-out, with the complicated problems of this group of disturbed clients.

STRENGTHENING THE PARENTAL ROLE OF ADULTS WITH CHARACTER DISORDERS

Frances H. Scherz

ONE OF THE GREATEST OBSTACLES to strengthening clients in their roles as parents is the difficulty of involving them in an examination of their own part in the child's problem and getting them to continue to work on the problem. This is particularly true of the parent who is suffering from a character disorder. It is also true of many parents of adolescents, particularly those who do not voluntarily seek help with their personal difficulties.

This paper presents some experimental work under way in the Jewish Family and Community Service of Chicago with parents and adolescents. Emphasis is placed on the use of joint and multiple interviews as a technique in strengthening parental roles. An intake interview and a case in treatment are described and analyzed.

For some time the agency has considered it imperative to have contact with the parents of an adolescent client during the exploratory process, and to have at least one parent involved in treatment, even if only minimally. This point of view is based on our conviction that: (1) the problems of the adolescent cannot be fully understood unless they are viewed in the context of the family situation; (2) the struggle for identity, which is the core developmental task of the adolescent, cannot be separated from the identity problems of his parents; and (3) our efforts to treat the adolescent are all too frequently limited in their effectiveness unless the destructive interaction between the youngster and his parents can be modified. Hence, the agency has required that the parents also be interviewed

by the worker. In many situations, it has been difficult, and sometimes impossible, to involve either one or both parents in any significant way.

Parents Who Resist Treatment

When we examined these cases, we found that many of the parents whom we had been unable to involve in treatment revealed certain characteristics common to character disorders: acting out as one of the main mechanisms in both the parents and the adolescent; little anxiety about the nature and cause of the problematic behavior but much fear of the social and legal consequences; impulsivity as a defense against anxiety and depression; low tolerance for frustration; little capacity for reflection; and poor communication among all family members. In short, these parents resembled those described in some of the recent literature.[1] Parents such as these generally come to the family agency because of strong external pressures from schools, courts, or other parts of the community. Negative feelings toward the adolescent, the referring source, and the agency are in the ascendancy. There is a marked tendency to blame the youngster, his friends, or the community, on the one hand; or to minimize or deny the problem, on the other. Both kinds of behavior are frequently an evidence of the need to evade the implications of parental responsibility for the child's difficulty. These parents are characteristically ambivalent about recognizing the seriousness of the problem and they show striking resistance to becoming involved in the treatment of the adolescent, especially when an attempt is made to focus on their own personal problems.

At the same time, we found that when the parents were not involved, we either failed to reach the adolescent or, when we did reach him, we often had to terminate treatment far short of the goal that had been hoped for. Termination occurred when the adolescent, serving as a balance wheel or scapegoat for destructive parental needs, improved to the point where family equilibrium was threatened. The parents then needed to interfere with, or

[1] Beatrice Simcox Reiner and Irving Kaufman, M.D., *Character Disorders in Parents of Delinquents*, Family Service Association of America, New York, 1959; Harris B. Peck, M.D., and Virginia Bellsmith, *Treatment of the Delinquent Adolescent*, Family Service Association of America, New York, 1954.

withdraw the adolescent from, treatment. In some instances, his improvement generated too much anxiety and guilt for one or both parents to tolerate. In others, gratification of the adolescent's unconscious need to be the scapegoat, to remain tied to his parents in a hostile-dependent or seductive relationship, to continue to provoke parental differenecs, or to remain in various ways in an immature relationship with his parents, could not be dealt with therapeutically unless destructive parental patterns could be shifted or altered.

We had observed that, when one parent is interviewed alone, there is likely to be an increase in resistance, distortions, exaggerations, and massive transference reactions. He seems to view every question or comment by the caseworker as a criticism or an attack. Moreover, he seems to feel peculiarly threatened by difficult adolescent behavior—perhaps because this stage of development tends to arouse in him, more than do other stages, conscious and unconscious memories, fears, feelings of confusion, longings and impulses that are difficult to bear. Perhaps he is threatened because he is no longer in complete control of the adolescent, because he can no longer hide behind the wish that the youngster will "grow out of it," or because this is his last chance to have his child succeed where he himself has failed.

We speculated that these parents might feel less exposed, threatened, and resistive if they were interviewed together at intake or early in the exploratory process; that despite serious differences they might have with each other, this approach might enable them to see that they shared a common concern—the adolescent child. Thus, they might be able to present themselves as parents rather than as individuals who had failed and who had personal problems. Perhaps they could gain sufficient support from each other to understand and accept the need for their involvement in treatment.

A Multiple Interview at Intake

Our agency had for some time been informing all persons who applied for help that they could elect to have an individual interview or to be seen with other members of the family. Parents of adolescents were invited to come in together, as well as with the adolescent, if they chose to do so.

The intake interview with the T family shows some of the values, as well as some of the technical problems, in multiple interviews.

Mrs. T had called the agency at the urgent suggestion of the school because Howard, who was 16, wanted to go into the army rather than return to high school. The father had refused to sign consent. On invitation, all three appeared. Howard seated himself near the caseworker's desk, his father was beside him, and his mother was almost behind the caseworker, on the fringe of the group. Howard began by saying that he wanted to join the army. There ensued an argument between Mr. T and Howard (which persisted through a good part of the interview), about whether or not the father would sign consent. Mrs. T said that Mr. T overprotected Howard and failed to discipline him. Mr. T shrugged, "So that's the way I am." He then described the current crisis. Howard, who always liked to sleep late, had refused to go to school one morning when he had overslept. Mr. T had agreed to his staying home at the time, but after two weeks he had tried to force Howard to return to school. Howard argued that he could get his high school education in the army; he would like army discipline; it would make him study. Howard told about his attending a school in New York the year before. This experience had failed because there had been too little discipline. Mrs. T remarked that Mr. T had kept running to New York to see how the boy was getting along. Mr. T stressed the importance of education and described his own hard life in Russia. Howard kept interrupting his father. The caseworker, a woman, asked him to stop doing this; he would have an opportunity to present his side. She commented that parents naturally wanted to make life easier for a child but that sometimes young people had to find their own way.

Mrs. T said that Mr. T never disciplined the boy; he was indulgent. Tears came to her eyes as she said that Mr. T would not let the boy cross the street alone. Howard responded that he wanted to go into the army to escape his father's overprotection. The worker commented on how quickly Howard could pick up on anything his parents said to reinforce his own position. Both parents laughed indulgently, and said that Howard should be a lawyer. Howard and Mr. T continued to argue. The caseworker intervened, saying that it sounded as if some of this argument were

based on making an issue for the sake of having an issue; that some of the energy could be directed into better channels; that educational and vocational goals were important matters. Howard began to argue, but when the caseworker smiled, agreed that he thought it was serious too. At this point, Mr. T admitted that he tended to worry too much about the children. When the caseworker asked if he thought he could change, he did not answer; but shortly afterward he said that he would probably have to sign consent if Howard refused to continue in school. Mrs. T laughed triumphantly. The caseworker commented that the disagreement between Mr. and Mrs. T over Howard was a serious complication. They protested that all they wanted was for Howard to behave differently; it was *his* problem. The caseworker agreed he had a big share in it. Howard said that it was all his father's fault. Mrs. T remained silent. The caseworker said that she could not believe that. At this point, Mr. T said that they ought to come back and talk some more about it—all of them. Mrs. T agreed, and after a moment Howard said he guessed he could put up with it.

At the conclusion of the interview Howard stepped over to shake the caseworker's hand and thank her. Mr. T, half way out the door, turned back to do so also. Mrs. T had gone ahead after making a courteous comment.

The goals of this interview were: (1) to involve the parents as well as the boy in ongoing work on the problem, (2) to identify the main problem, and (3) to secure diagnostic clues to the specifics of the problem for purposes of further exploration.

Values in the Multiple Interview

Perhaps the most significant factor in involving the parents is the direct feeling experience of the interview. The immediate area of concern, the thing that "hurts," is being lived and dealt with in an interactional experience that is new to them because of intervention by a therapeutic agent. The over-all permissive attitude of the caseworker creates a reassuring climate in which each family member can bring out his feelings to the best of his ability. It impels each one to listen to the others in a way that is often a new experience. Although each person has his own unique capacity for viewing the problem and the caseworker with some

degree of ego perception—or at the other end of the scale may reveal massive repetitive transference reactions that distort his realistic awareness of the problem—the therapeutic interactional experience with other family members appears both to enhance the ego's observational capacities and to dilute transference reactions. The situation tends to become safer and less threatening to individual self-esteem.

Appropriate intervention by the caseworker affords protection to each person, so that emergency defenses, so commonly called into play at intake, may be reduced. After support was given by the caseworker Mr. T could admit to certain tendencies, thereby enabling Howard at least to stop and consider his headlong rush into the army. The T family experienced not only protection but the caseworker's control of the situation, thus there was less tendency to act out unproductively in the interview. Because the parents are viewed as parents who have differences but also common concerns, they seem to gain some support from each other and can begin to become aware of the need for their active participation.

In the T case, the caseworker "took sides" now with one, now with another, but always in the interests of the total family. She did not permit Howard to dominate the interview or to best his father. The caseworker provided a valuable experience for Howard by supporting the parents in their natural wish for a good life for the boy, and by showing that she respected them. She not only made clear the need for a realistic approach to the problem, but by refusing to accept the problem as a unilateral one, she strengthened the parents' wavering motivation toward involving themselves in its solution.

In a joint or multiple interview, both the clients and the caseworker seem more readily able to identify the problem. Perhaps the process of group interaction, with the safeguards and controls exercised by the caseworker, frees the clients to bring out the manifest and latent content of the problem. The caseworker, also feeling the protection of the group situation, can more directly and actively delineate and highlight the problem. Perhaps he feels freer to do this because in the multiple interview elements of health tend to emerge more quickly than in an individual intake interview, and can be used on the spot. It may also be that the sense

of shared responsibility, conveyed in viewing the problem as one of interaction rather than of personal responsibility, enables the parents to reveal the problem with less fear. In the T case, although differences between the parents were a vital factor, the caseworker was freer in stating that the problem was shared because she could present it as a problem in interaction rather than as a personal difficulty. It seems valid to postulate that bringing the problem out in the open affords some relief that leads to an acceptance of the problem and the enhancement of motivation to work on it.

The multiple interview at intake *offers particularly rich diagnostic material in two areas—family interaction, and its relationship to individual dynamics.* This material furnishes important clues to the selection of the specific areas that require further exploration, and for deciding how and with whom to proceed. For example, Mrs. T subtly provoked dissension between father and son, and she abetted the father's acting out in the school situation by not taking any responsibility herself. Howard used his mother's complaints against his father to gain his own ends; he allied himself with his mother in depreciating his father. There are clues indicating that Mr. T may have taken a maternal role with Howard, with or without Mrs. T's tacit consent. Some of these clues could be discerned in the nonverbal communication, the seating arrangement, the glances, the laughter, and so on.

This type of interview at intake does not necessarily produce genetic or clinical information. It does give a picture of the clients' adaptive patterns and the types of defenses used in family interaction. In the T case, the caseworker concluded that all three family members should be worked with, and that Mrs. T, because of her seeming fringe behavior and subtle provocativeness, should be interviewed alone the next time. It was also her impression that the crucial area for exploration was the parents' possible tendency to act out through the boy.

In retrospect the caseworker concluded that there were certain things she should have done differently. She should have made more effort to involve Mrs. T by eliciting her reactions to the arguments between Howard and his father and by inquiring about her own feelings and behavior in regard to Howard's school failures. She could have made clearer to Howard his parents' rights and feelings and could have pointed out to him that the army is also a

protected situation such as he complains about. She could have strengthened Mr. T by asking Howard if, at home also, he does not permit his father to express his point of view. If the caseworker had done these things, the desirability of a second multiple interview to consolidate the involvement of the family members and to identify further the nature of constructive and destructive interaction would have been clarified.

This interview and the worker's retrospective thoughts reveal how difficult it is to handle a multiple interview. The caseworker must become an intrinsic member of the interactional process, giving of himself generously and spontaneously to each individual, yet always keeping in mind the nature of the family interaction and the effect of his responses on each person, as well as on the total group. There is less opportunity than in a one-to-one interview to think and weigh responses; much must be done by "clinical hunch." A fine line must be drawn between permitting the ventilation of hostility, and controlling the type of acting out that renders the interview futile. Doing this is particularly difficult but necessary when the caseworker suspects that he is dealing with character disorders in which control without negative suppression is important.

Maintaining appropriate identification with each family member is exceedingly complicated at best. It is even more difficult with parents who have character problems since they have so little tolerance for frustration, are so competitive, and are uncannily quick to sense any slight to their shaky self-esteem. They need tangible evidence of being respected, but they also look for protection against their acting-out proclivities. In the T case, the worker tried to maintain a balance in identification so that no one would feel demeaned or rejected. Had she not been successful, the case might have been lost or there might have been an increase in the clients' acting out. It is natural to identify with an adolescent; overidentification with him or with the parents—although the latter is less common—can have serious consequences.

The caseworker also has considerable opportunity to observe and deal with non-verbal communication. It can be somewhat unnerving to a worker to realize that his own non-verbal communications are under considerable scrutiny and are used in different ways by each client. The caseworker's discomfort when parents expose their weaknesses to the adolescent and the latter is exposed to

anger and depreciation by the parents can be alleviated by the comforting knowledge that this behavior goes on continually in the home. It is no secret to anyone. At the least, it may be possible for the caseworker to deal with these exposures in a therapeutic manner in the interview.

Initial Treatment Phase

Many of these same elements appear to operate in the ongoing treatment process with the parents of adolescents. Our experience has led us to speculate that multiple or joint treatment interviews may be particularly useful. The J case is an illustration.

The J family was referred in June, 1958, by the high school which Jim, aged 16, attended. Throughout elementary school and high school, periodic attempts had been made to refer the family because Jim, who had an I.Q. of 135, had always had difficulties in learning and school adjustment. Presently he was engaged in mildly delinquent activities.

Mrs. J, bright, disheveled, hostile, and tense, had always lived with her mother, to whom she was tied in an adolescent hostile-dependent relationship. The grandmother, now 86, supported the household from money left by her husband. Mrs. J, a college graduate, was very active in the PTA, and was in constant conflict with Jim's teachers. Mr. J, who was non-Jewish, looked deteriorated. He was a college graduate, an only child who had been overprotected and infantilized by his mother. He had never had a job and had never succeeded at anything. The home was filthy and disorganized.

Susan, aged 15, also had problems, but it was Jim who bore the brunt of both parents' frustrations. The marriage had always been stormy, with violent physical battles over Mr. J's affairs with other women and his episodic but heavy drinking. When his father was drinking heavily, Jim would intervene, defend his mother, and put his father to bed. Mrs. J appeared to be satisfied only when she had Mr. J under her thumb, at home. He spent his time writing futile articles on economics and vitriolic letters to newspapers. Mrs. J consistently undermined any efforts Jim made to succeed, but at the same time she pressed the school to promote him.

Jim, alert but dirty, could barely spell and could not write legibly. He rationalized his failures and blamed them on his teachers, the

dullness of his classes, and so on. He chose as friends bright, emotionally disturbed youngsters who engaged in semi-delinquent activities. He spent much of his time fantasying about wealth, and was inordinately preoccupied with daydreaming about fast racing cars. He roamed the neighborhood late at night, lost in fantasy.

Mr. J came to the agency only once and refused to return. Because of the many appointments broken by Mrs. J and Jim, the exploratory phase covered a period of eight months. It became clear that both Mr. and Mrs. J were suffering from character disorders and that Jim was moving in this direction. Mr. J was weak and dependent; Mrs. J, manipulative and angry, was unable to accept anything good for herself. The strong, dominant grandmother, with her constant degrading of Mr. J and her tendency to quarrel about religious differences, compounded the family's problems. Mrs. J aggravated the failures of her husband and son. She could not permit Mr. J to come to the agency and subtly prevented Jim from making use of treatment.

During the initial treatment phase, from January to August, 1959, the same caseworker, a woman, worked with Mrs. J and Jim individually. There were many broken appointments. The worker's immediate treatment goal for Mrs. J was to establish a relationship with her by identifying with her intense feelings of frustration, her wish to run away from her problems, and her need for some dependency gratification. Mrs. J was permitted to ventilate her feelings of anger toward her husband, her son, and the caseworker. The worker stressed Mrs. J's right to have something better for herself, to seek ways of obtaining it, and to have greater self-esteem. She was encouraged to make realistic demands on the members of her family. The worker made no attempt to help Mrs. J understand the "why" of her behavior lest she become depressed or act out even more. Some gains were made. Mrs. J took a part-time job, bought herself some clothing, and did not run to Jim's school so frequently. She still engaged in projection, but her hostility toward and curiosity about the caseworker began to abate.

The worker's treatment goal with Jim was the improvement of his concept of himself through modifying those defenses that were self-destructive and limiting. Although the worker permitted him to reveal his fantasies for the purpose of ventilating his aggressions,

she tried to direct him toward constructive action. She tried to help him realize that he would not destroy his father even if he did surpass him. Efforts were made to raise his self-esteem by working with him on such matters as school adjustment, friends, and an identification with lawful groups. Moreover, the worker tried to help Jim realize that he did not need to have his mother regulate and manipulate his environment; he did not have to accept her weaknesses or compromises. Firm pressure was put on him to stop squandering himself. Owing to the long-standing nature of the problem and to Mrs. J's interference, Jim's movement toward these goals was only slight. He developed only a superficial relationship with the worker. He could describe his problem in an intellectual manner but could not deal with it. He retreated often into fantasy. Toward the end of this period, however, he began to verbalize real anger toward his father, his need for his father's protection and support, and his confused feelings toward his mother.

Shift in Treatment Approach

In August, 1959, when the case had to be transferred, the treatment goals and methodology were reviewed. It seemed necessary, somehow, to involve Mr. J in treatment and to test the ability of each parent to fulfil his parental role, since it had not been possible to interrupt the destructive acting out that was taking place between Jim and his mother. It was decided that the new caseworker, a man, should plan to have joint interviews with Mr. and Mrs. J and individual interviews with Jim. Stress would be placed on the fact that both parents were genuinely concerned about Jim. It was hoped that this approach would reduce the parents' need to act out through Jim and with each other.

In this second phase of treatment, which is still continuing, there have been no broken appointments. In the first few joint interviews Mr. and Mrs. J aired their dissatisfactions with each other and their feelings of hopelessness. Mrs. J was depressed. She was hostile toward Mr. J and blamed him for Jim's school failure. Mr. J blamed the poor neighborhood, the inferior teachers, and so on. The caseworker acknowledged that the environment had certain limitations but would not accept this as the full explanation for Jim's failures. He strongly supported their concern about Jim,

and expressed his conviction that both of them were capable of pulling together in Jim's behalf. He would not permit unbridled acting out in the interviews. Mr. and Mrs. J began to speak of the caseworker's being their "equal." By this they meant that he could help them to control their acting out with each other. They felt that he was interested not only in Jim but in them. He insisted that they handle certain specific matters such as planning Jim's allowance, setting his hours, and seeing that he had new clothing. Mrs. J's reaction was reflected in her statement, "We feel as if we aren't so bad after all." Success in these areas enabled the caseworker to move into helping the parents see how their conflicting decisions and displacement of dissatisfactions onto Jim were destructive to him and to themselves.

Concurrently, the caseworker also held individual interviews with Jim. Treatment continued along the lines that had been planned earlier. Jim expressed pleasure that his mother and father were working together for him. He concentrated on school work, and passed all subjects but one in January, 1960. With the parents' support he enrolled in a group work center, an undertaking that required real effort on his part since it involved considerable travel and his forming new relationships. By the end of March he was placed in charge of the game room at the center. The parents actively supported his casework treatment.

In January, 1960, the worker decided to have interviews with all three clients together, twice monthly. Joint interviews with the parents and individual interviews with Jim were continued. Multiple interviews were used for two purposes: (1) to further the beginning integration of the family as a unit, and (2) to interrupt the gratification Jim was getting from being able to play one parent against the other, and thereby to speed up his rate of improvement. In the first few multiple interviews Jim attempted to pit the caseworker against his parents and his parents against each other by such statements as "Mr. R thinks Dad is no good and should be working," or "Mr. R thinks Mother should not spend so much time on PTA activities." The caseworker repeatedly explained his own role in relation to each client. He refused to permit Jim to denigrate his parents or the parents to attack Jim and each other. He pointed out, to Jim and his parents, their destructive behavior toward each

other and the personal limitations each should accept in the others. He upheld the parents' right to behave as parents, and Jim's right to make valid choices and decisions. Although the basically poor relationship between Mr. and Mrs. J has not improved, each of them has been somewhat strengthened in the parental role. All three of them look better; the home is somewhat more organized; and the parents report that Susan is not so great a problem. Jim's concept of himself has improved and he is beginning to establish his own identity.

In retrospect, one might conclude that joint and multiple interviews could have been established at an earlier point in this case. Perhaps a combination of these and individual interviews might have moved treatment more productively and more rapidly. However, it may also be that, owing to her strong dependency needs and immature, narcissistic orientation to life, Mrs. J had to establish a firm relationship with the worker before joint or multiple interviews could be undertaken.

Areas of Speculation

The J case does raise some further questions on which one might speculate:

1. *The nature of the casework relationship.* Parents with character disorders often behave like rivalrous, hungry siblings who discharge tension mainly by acting out. It may be that through casework treatment the parents learn that there are others with similar problems; that neither one is singled out to be blamed or is rejected; that love can be given to more than one child; and that it is not necessary to act out in order to obtain dependency gratification. Perhaps it is through learning these things that they are gradually enabled to improve their behavior as parents. Since the person with a character disorder acts rather than reflects, his perception of his partner's needs may be improved by having contact with a benign, but firm, parental figure, who can handle his competitiveness and who can find a balance between accepting the client as he is and demanding better performance of him. Although this experience can be provided in individual interviews, it may be even more meaningful in a joint interview. The experience of learning these things together in an interactional process, the fact that respon-

sibility is shared, that the worker therapeutically makes demands on both parents and that he appeals to the strengths of the partners as parents, enable them to tolerate frustration more readily, to feel less personally threatened, and hence to become better able to work together on behalf of their child. It is possible that, although they continue to relate to each other as siblings, the parents can begin to feel some tenderness for each other as the acting out diminishes. Since treatment efforts are directed toward the interactional process as well as their individual needs, the parents may not need to invest the caseworker with the magical power of destruction with which they invested their own parents. Hence, they can better accept the gratification of their dependency needs as well as the worker's demands for more mature behavior. Little is yet known about the nature of transference phenomena in the joint interview. Perhaps, as caseworkers experiment and gather more data, it will be found that, in the joint interview, transference and countertransference phenomena are quite different in nature and intensity.

2. *The nature of the interactional process.* The reactivation of unresolved oedipal problems, which characteristically occurs in the parent of an adolescent and is striking in the parent with a character disorder, seems to be a significant factor in the parent's interfering with or sabotaging the treatment of the adolescent. This was evident in the J case. Mrs. J could not permit Jim to succeed or to use treatment, yet she could begin to permit both when joint interviews were instituted. The mother needed to act out through the boy in order to control her anxiety about the upsurge of her own oedipal feelings. Why this phenomenon seems more manageable in joint interviews is not clear. Perhaps the support afforded her by Mr. J in his assumption of a stronger male parental role alleviated Mrs. J's anxiety sufficiently that repressive forces could again submerge the active oedipal content. The worker's active focus on the parental role may have helped Mrs. J's ego to assume better control over interfering instinctual impulses and needs. Although the worker did not ignore the marital conflict and the parents' personal problems, his dealing with them indirectly, while maintaining his focus on the parental role, may have allayed or modified anxieties stemming from personal inadequacies.

The caseworker's part in the interactional process changes as

treatment progresses. In the J case, the first phase in the use of joint interviews was directed to specific activities from which the parents could derive some feeling of mastery, and of achieving things together. Although they were permitted to ventilate hostility, their common concern for Jim was stressed. The caseworker exerted control while simultaneously pushing them toward appropriate activity, holding out hope, and giving praise when they were successful. When it seemed to him that the parents had made sufficient gains, he began to deal with their destructive behavior and the need for change.

Clarification was limited to helping the client look at the "how" of behavior. Because the worker used this technique with both partners, it was more acceptable to them. It is hoped that in the next treatment phase (as has happened in other cases), Mr. and Mrs. J will begin to discuss their differences and agreements more with each other and will assume with each other something of a therapeutic role. That is, it is hoped that each one will help the other discuss his own problems and will give support by showing him both understanding and acceptance. When this happens in a marriage, each partner can begin to acquire a better self-image and to identify with the other. The caseworker then becomes less an introjected parent, and there is less need for him to control or manage the interviews. His active intervention then takes the form of clarification to increase the partners' abilities to perceive their own and each other's needs and capacities. In some cases, this may be sufficient to bring about improvement. In others, neurotic components may come to the fore that will require individual treatment.

In the J case, when the caseworker thought that the parents were strengthened sufficiently, he included Jim in the multiple interactional process. As was to be expected, some of the same process that characterized the early treatment phase had to be repeated—the competitiveness of the parents with each other and Jim for the attention of the caseworker, the venting of hostility toward each other, the caseworker's exercise of active control and balanced identification, and gradually his use of the experience to show Jim he was interfering with his own developmental needs by behaving toward his parents as he did. No one's problems were minimized but therapeutic demands were made on each to accept the limita-

tions of the others. Jim began to separate himself from his parents and establish his own identity. It is doubtful that he could have moved so rapidly in this direction if Mr. and Mrs. J's growing identity as parents had not afforded him support.

The caseworker's activity in treatment was related to both nonverbal and verbal interaction. In some instances, although not in the J case, what is communicated indicates a need for individual interviews as well. For example, the depression that may occur when the parent experiences a growing sense of his own identity may require treatment techniques such as support or clarification that are best used in individual interviews. The parent's shame about exposing irrational attitudes may also have to be handled individually. Likewise, although the parents' massive destructive support of each other in a solid front against the caseworker may be pointed out in joint interviews, it may have to be dealt with in separate interviews.

This paper has emphasized the speculative nature of much of the theoretical content. There is a growing body of experience, however, that points to the value of joint and multiple interviews in strengthening parents in their parental roles, particularly those parents who are suffering from character disorders.

SOME RELEVANT DIRECTIONS FOR RESEARCH IN JUVENILE DELINQUENCY

Irwin Deutscher, Ph.D.

UNLIKE MORE STATIC and less complex societies, ours is characterized by an ever-varying progression of fads and fashions—in clothing, housing, food, religion, education, child rearing patterns, and social problems.[1] Professional publics, as well as so called lay publics, are susceptible to seduction by such popular movements. It is hardly coincidence that sociologists and psychologists manifest a heightened intensity in their research on such phenomena as the adjustment of European immigrants to American urban life, conflict between labor and management, race relations, problems of the family, the organization and purpose of our prisons and penitentiaries, mental health, and so on, at times when there is great popular interest in these matters. Perhaps the most fashionable bandwagon rolling today is the one that flies the banner bearing that amorphous legend "Juvenile Delinquency."

The only reasonable conclusion that can be drawn from the sometimes invalid and frequently unreliable data on delinquency trends is that there is no consistent evidence of any general increase in the rates of misbehavior among children and adolescents.

In an excellent discussion of the pros and cons in interpreting delinquency trends, Teeters and Matza present delinquency rates from 1918 to 1957 for the Cleveland area. By and large those rates

[1] For analyses of the role of fad and fashion see Herbert Blumer, "Collective Behavior," *New Outline of the Principles of Sociology*, Alfred McClung Lee (ed.), Barnes and Noble, New York, 1946, pp. 217–218; Richard T. La Piere, *Collective Behavior*, McGraw-Hill, New York, 1938, pp. 185–195; Ralph H. Turner and Lewis M. Killian, *Collective Behavior*, Prentice-Hall, Englewood Cliffs, N. J., 1957, pp. 207–217.

were considerably higher during the years 1918 to 1934 than they were in 1957. In the late thirties they dropped somewhat only to rise again during World War II.[2] Monahan has contrasted 1923 data with the years 1949 to 1954 in Philadelphia, and the curves show practically no difference in delinquency rates in these two periods of time.[3] In Buffalo, New York, the delinquency rate (for ages 7 to 15) in 1957 was almost identical to the rate in 1950 with only minor variations during the intervening years. In that city the trend in youth arrests (for ages 16 to 20) shows a steady decline during the decade 1947 to 1957.[4] Statistics from the District of Columbia show a constant decline in that city's delinquency index between the years 1954 and 1958.[5] In the county containing Syracuse, New York, the delinquency rates in 1957 were almost identical with those in 1940. The City Youth Bureau rates when taken alone show a decline in the rate per thousand (for ages 7 to 15) from 51 in 1950 to 43 in 1957.[6] The New York State Youth Commission reports that in 1959 delinquency rates in the upstate area were the lowest in twenty-two years and in New York City they were lower in 1959 than they had been in the preceding year.[7]

The data cited above are derived largely from studies focused on limited geographic areas. When large quantities of data, presumably describing delinquency in the United States as a whole, are thrown together, the conclusions drawn are usually the reverse: such data tend to show an alarming upsurge in delinquency. For example, the Federal Bureau of Investigation's *Uniform Crime Reports* indicate a continuing rise in delinquency since the immediate postwar decline. On the basis of this data, the Children's Bureau tells us that "Juvenile delinquency in the United States . . . has increased each

[2] Negley K. Teeters and David Matza, "The Extent of Delinquency in the United States," *The Journal of Negro Education*, Vol. XXVIII, No. 3 (1959), pp. 200–213. It is interesting to note that the wartime rise and fall revealed in most statistics is not as pronounced in the Cleveland area.

[3] Thomas P. Monahan, "On the Incidence of Delinquency," *Social Forces*, Vol. XXXIX, No. 1 (1960), pp. 66–72.

[4] *Delinquency and Youth Crime*, A Research Report of the Buffalo Youth Board, Buffalo, N. Y. 1958, pp. 4–6.

[5] *A Delinquency Index for the District of Columbia*, Interdepartmental Committee of the District Government, Washington, D. C., March 9, 1959, p. 2, (mimeographed).

[6] *Progress Report on Inventory Research*, Youth Development Center, Syracuse, N. Y., November 20, 1958, p. 2 (Ditto).

[7] "Delinquency Drops in City and State," *The New York Times*, April 25, 1960.

year for the past decade." [8] Because the data on limited geographic areas tend to be based on more consistent sources and to be generally more reliable, both in their gathering and analysis, I am personally inclined to lean toward the studies indicating consistency, if not decline, in delinquency rates. However, it is not my intention to derogate data indicating otherwise. Such sophisticated observers as Bloch and Flynn have concluded, largely on the basis of the FBI data, that "juvenile delinquency cases are rising." [9] Although there is an obvious difference between numbers of cases and rates standardized to compensate for shifts in the age composition of the population, Teeters and Matza have shown that the difference between rates and numbers is usually not enough to account for the variations observed through time.[10] There are exceptions, however. Contrary to the declining rates indicated by the New York State Youth Commission, the State Charities Aid Association in 1959 reported sharp and consistent increases both in New York City and in upstate New York.[11] A re-analysis of these data, employing age standardized rates rather than percentage increases originally reported, reveals no changes through time.[12]

My purpose is not to document the well known fact that statistics in this area are often inconsistent, nor is it to remind readers that we do not actually know that there has been any increase in misbehavior among children and adolescents in recent years. Rather, the point I wish to make is simply that it makes no difference what the figures tell us because the actual behavior of the youngsters involved is not the only factor in the creation of a social problem. A social problem definitely exists—we have a delinquency problem

[8] *A Look at Juvenile Delinquency,* Children's Bureau Publication No. 380, Government Printing Office, Washington, D. C., 1960, pp. 2–3. See also: *Report to the Congress on Juvenile Delinquency,* Children's Bureau and National Institute of Mental Health, U. S. Department of Health, Education and Welfare, Washington, D. C., pp. 3–4.

[9] Herbert A. Bloch and Frank T. Flynn, *Delinquency: The Juvenile Offender in America Today,* Random House, New York, 1956, p. 33.

[10] Teeters and Matza, *op. cit.,* p. 207.

[11] *Youth in Custody,* Part II, The State Committee on Children and Public Welfare of the State Charities Aid Association, New York, N. Y. January, 1959, p. 1.

[12] Unpublished communication from Kenneth W. Kindelsperger, Syracuse University Youth Development Center, to David Hunter, The Ford Foundation, July, 1959.

regardless of what the statistics say and regardless of how many young people are behaving or misbehaving.

Direction 1: Research on Public Images of Children and Adolescents

The first relevant direction I would propose for research in juvenile delinquency is that we consider definitions of delinquency and public reactions to it. The fact that adolescents do not always behave in the ways adults would prefer that they behave creates a problem. The popular catchall phrase which has become fashionable in describing this problem is "juvenile delinquency." Note that there are two independent factors that make this a problem (in addition to giving it a name): (1) the behavior of the adolescents and (2) the reaction of the adult community. It is true of any social problem that it can be defined as a relationship between these two factors: behavior on the one hand, and reactions to that behavior on the other. Van Vechten has expressed this phenomenon in terms of what he calls a "tolerance quotient." [13] Taking some liberties with his formulation, we can put it this way:

$$\text{Extent of a Social Problem} = \frac{\text{Amount of Deviant Behavior}}{\text{Amount of Community Tolerance}}$$

It is apparent that this ratio can become large either through an increase in the numerator (in our case, delinquent behavior), or a decrease in the denominator (community tolerance of adolescent misbehavior). It goes without saying that a sudden surge in one (real or apparent) can create a reaction in the other, and a spiraling effect can be produced, similar, for example, to the relationship between steel prices and steelworkers' wages.

This reasoning suggests a double-barreled approach to the problem. We can examine the behavior of adolescents and we can examine the public reaction to that behavior. I am under the impression that there has been little if any research on public images of adolescent misbehavior and, in terms of the above definition of a social problem, this is just as important a phenomenon

[13] C. Van Vechten, "The Tolerance Quotient as a Device for Defining Certain Social Concepts," *American Journal of Sociology*, Vol. XLVI, No. 1 (1940), pp. 35–42. For an attempt to apply this concept to a number of diverse social problems see Edwin M. Lemert, *Social Pathology*, McGraw-Hill, New York, 1951.

for research as the behavior itself. There are, of course, many publics and they have varying influences on the self-concepts (and therefore the behavior) of adolescent boys. For example, what are the differential images held by peers, by girls, by teachers, by parents, by policemen, by businessmen, and so on? People react toward others in terms of the images they hold of those others; and the reaction of others is a determining factor in the image we hold of ourselves.

The socio-psychological problem of the relationship between self-definition and definition by others, is of crucial importance to those concerned with the problem of early identification and with that creature known as the "pre-delinquent." Exactly what is the effect on a child's definition of himself and his expected role in society if he is labeled as a delinquent or pre-delinquent? What is the effect on others (teachers, parents, peers, neighbors, and so on) to know that such a label has been applied? How is the interaction process and eventually the socialization process affected by such naming or identification? We have emotional answers to these questions and we have theoretical answers, but we have no empirical evidence.

I submit that all of us, by our interest and concern, have in part created that social problem we call juvenile delinquency and we would do well to step back and take a look at the role we respectable middle-class citizens with a social conscience have played and continue to play in creating an increasingly problem-laden atmosphere.

Direction 2: The Development of Operational Typologies

It should be apparent by now, that I hold certain reservations regarding the term "juvenile delinquency." One of the best recognized and most poorly coped with problems in research, on social problems in general and delinquency in particular, concerns the unit of study. To lump under one rubric—or one behavioral concept—a 9-year-old girl who runs away from home, the zip-gun-toting members of a Manhattan bopping gang, the calculating groups of adolescents who methodically and efficiently strip cars and dispose of their produce through a fence, and the teen-age Kansas boy who deliberately blasts his father's head off with the family shotgun, is patently

absurd. Any research that employs such a concept in endeavoring to understand the behavior of children or adolescents must be equally absurd.

There is a desperate need to identify homogeneous kinds of behavior which may represent types scientifically, in place of the legal, clinical, or correctional categories which have been established for other purposes. Such typologies need to have solid roots in current social science theory and need to distinguish clear and meaningful categories of behavior (or misbehavior) which "make sense" empirically. For example, Donald Cressey,[14] following Sutherland,[15] has taken some steps toward thinking through a theory of "behavior systems," of which we ought to take cognizance and which might facilitate the development of a set of typologies of so-called delinquent behavior. More recently Cloward and Ohlin,[16] drawing on Merton's classic formulation of "Social Structure and Anomie," have developed a theory of opportunity systems which differentiates types of youthful gangs in a manner that is theoretically sound and empirically reasonable. No such conceptual system can hope to encompass the totality of the hodge-podge that is labeled "delinquency." Much of such behavior is not sufficiently systematic to fall under the umbrella of Cressey's "behavior systems," and certainly most of us would be interested in more than the organized gang behavior studied by Cloward and Ohlin which is found largely in the most densely populated urban centers. There have been, of course, other efforts in the direction of classification [17] but much more intensive and systematic work is needed in this area. Once we have succeeded in identifying different homogeneous types, we shall have cleared away much of the confusion that results from attempting to study adolescent misbehavior as if it were a single phenomenon.

[14] Donald R. Cressey, "Criminological Research and the Definition of Crimes," *American Journal of Sociology*, Vol. LVI, No. 6 (1951), pp. 546–551.

[15] Edwin H. Sutherland, *Principles of Criminology*, J. B. Lippincott, Philadelphia, 1934.

[16] Richard Cloward and Lloyd E. Ohlin, *Delinquency and Opportunity*, The Free Press, Glencoe, Ill., 1960.

[17] Cf. William C. Kvaraceus and Walter B. Miller, *Delinquent Behavior*, National Education Association, Juvenile Delinquency Project, Washington, D.C., 1959, pp. 50–55; L. E. Hewitt and Richard L. Jenkins, *Fundamental Patterns of Maladjustment*, State of Illinois, Springfield, Ill., 1946.

Direction 3: The Shift From "Factors" to "Process"

In discussing the need for theoretical typologies, I wish to make it clear that I am referring to types or categories of behavior or motivation, *not to types of people or personalities.* Perhaps the foremost reason why we have so little understanding of the processes that lead to deviant behavior is because we have seldom bothered to look for them. Rather, we have dissipated our research energies in a fruitless search for factors, bewildering ourselves, in our quest for "causes," with the fallacious behavioristic assumption of stimulus-response. We might better have retained the old belief that people who misbehave are inherently depraved either as a result of the influence of the devil or the defectiveness of their genetic composition. The older assumption was at least not as wasteful of research funds, intellectual energies, or clinical time.

Although these "factor" schools vary in content, the principle is constant: there are certain traits or characteristics that distinguish deviant types from the rest of us. They may be stupid (mentally deficient is the euphemism), pear-shaped, slack-jawed, epileptic, psychotic, poor, orphaned, or have any one or a combination of personality, family, or social traits. In effect, the factors suggested may be sociological, psychological, psychiatric, biological, physical, or economic. All of them entertain the same fallacious notion that there is a simple cause that brings about misbehavior. Currently popular "causes" of delinquency range from severe toilet training to watching television, from the existence of working mothers to the absence of reading skills. Obviously, none of these, or any other that might be fashionable at a given moment, is a necessary and sufficient cause of adolescent misbehavior. There were, for example, delinquents before the advent of television and there are today delinquents who do not watch TV, and certainly many young people do watch TV without behaving abominably as a result. Any purported "cause" must fail such tests of validity.

What our research must seek to achieve is an understanding of the varieties of socialization—the ongoing life careers of young people with their frequent crises and turning points, their alternatives and choices, and the patterns of the paths that develop. Studies in this area will lead to an understanding of both conforming and

deviant behavior and the routes that lead to both. What kinds of deviant behavior are harmless, short expeditions without permanent consequences and with a rapid return to the routes of conformity? What kinds of misbehavior lead to other kinds that eventuate in a sequence of behavior that may be identified as a delinquent career? Can we identify potentially dangerous configurations of decisions or choices among adolescents? What sorts of day-to-day crises do adolescents see themselves confronted with? To what extent do they resolve these crises themselves and to what extent are they resolved for them by others? What is the differential influence of "others" (peers, adults, parents, teachers, and so on) on the adolescent decision-making process? Can we identify empirical typologies representing varieties of adolescent careers?

These are the kinds of questions we should be asking as guides to our research. The basic assumption involved in this approach is that misbehavior, like any other kind of behavior, comes about through the general processes of socialization. Regardless of personal traits or characteristics, any individual under the proper configuration of circumstances and associations can become a criminal, a drug addict, a drunk, a delinquent, or what have you. As E. H. Sutherland phrases it: ". . . the development of criminal behavior is considered as involving the same learning processes as does the development of the behavior of a banker, waitress, or a doctor. The content of learning, not the process itself, is considered as the significant element determining whether one becomes a criminal or a non-criminal." [18]

Direction 4: Knowledge of Norms Is Essential to Understanding Deviations

Sutherland's statement provides a natural bridge to the final direction for research which I should like to propose. If the difference between the deviant and the conformist lies in the differential contents of learning during the socialization process, a crucial area for study must be those points at which the deviant finds himself departing from the orbit of conformity and those influences that

[18] Edwin H. Sutherland, *op. cit.*, p. 58.

exert gravitational pressures both away from and back toward the conforming behavior. Before we can understand any kind of deviation, we must have some grasp of the norm from which that deviation occurs. If I may use an analogy, it would seem apparent that without a basic understanding of normal skin tissue development there is no possibility for corrective measures in cases of skin cancer. Moving closer to home, we must concede that sociologists have fumbled for decades with the concept of social disorganization largely because of a failure to recognize the prerequisite need to understand social organization. What I am saying is that we cannot hope to understand the processes leading to delinquent behaviors without understanding the conforming or non-delinquent paths from which they diverge.

Conceptual clues to the approach to this kind of research already exist in the theoretical literature. For example, Ruth Benedict, in a classic paper, has spelled out one of the crucial trouble spots in the socialization process.[19] Her concept of "Continuities and Discontinuities in Cultural Conditioning" is particularly relevant to the study of the growth and development problems of the contemporary American (and perhaps urban European) adolescent. We could probably learn a great deal by looking into the ways in which we do and do not provide continuous evolutionary processes by which a child can make the transition to adulthood without trauma. Or, at least, accepting the system for what it is, we might seek to identify the ways in which some children manage to attain some success in beating the system and achieving adulthood without getting into trouble.

Other Suggestions on Research in Delinquency

Having suggested what I feel to be some of the more relevant directions for future research in delinquency to take, I feel compelled to clarify a few residual matters. Such directions will lead to better comprehension of the "how" and "why" of the behavior of young people. Studying the "how" involves focusing upon the dynamics underlying behavior. Studying the "why" means focusing

[19] Ruth Benedict, "Continuities and Discontinuities in Cultural Conditioning," *Psychiatry*, Vol. I. No. 2 (1938), pp. 161–167.

upon the earlier sequence of experience which has resulted in the current pattern of behavior. Such knowledge will ultimately help reduce occurrences of undesirable behavior among children and adolescents or, stated positively, will help them in the development of more adaptive behavior.[20] When I speak of the reduction of occurrences I am referring to *prevention rather than cure.* An understanding of the process—of the pathways—leading to various forms of delinquent and non-delinquent behavior will enable us to intervene in that process when conditions indicate the beginning of maladaptive careers. If we know how and where the socialization process goes "wrong," we shall be in a position to deflect it before it does so.

The most effective means of relieving the pressures now bearing down on the many clinicians attempting to cope with delinquent children is to find ways of reducing the number of children needing clinical help. Therapy, counseling, and casework are slow processes largely oriented to individual patients or clients. For every child who benefits by such treatment, there are at least two others waiting to take his place. Individual treatment does not appear to be an efficient means of coping with a large scale social problem. It provides little more than a stopgap—a valiant effort to do what is possible to hold the line until effective preventive measures can be evolved. I might add that, compared to the clinical judgment of the knowledgeable and experienced practitioner, research has little to offer toward the improvement of treatment.

Finally, I should like to point out that an inherent danger in the kinds of research I have been suggesting is to assume some sort of group determinism. It is fallacious to see adolescent careers as if they were a railroad track with occasional switching points at which the person can be shoved onto another line. As important as the influence of others is on our lives, we are not simply pushed around by them. The individual himself partakes in the process and influences it; he is not a helpless pawn in the grasp of the conformity-

[20] This paragraph is paraphrased from "A General Research Orientation for the Syracuse University Youth Development Center," a staff paper edited by the present writer and published by the Center. I particularly wish to acknowledge the assistance of David Hunt in the formulation of the ideas expressed in this paragraph, as well as elsewhere.

demanding group. Knowledge of the ways in which innovation and change develop within the group is important and is now largely lacking. Cohen touches on this problem briefly in his discussion of how subcultural solutions arise within boys' gangs.[21] We must, of course, be interested in adolescent subcultures and in the manner in which change can be induced in them. Personally, I think that humor is one of the basic "exploratory gestures" (as Cohen calls them) through which shifts in values are channeled. If we could learn more about the nature and function of adolescent humor we might learn how change takes place in adolescent values.

Summary

In this paper I have asked that more research energy be expended on the effect that others—particularly adults—have on the creation of juvenile delinquency and on the concepts of themselves which young people develop as a result of adult definitions. I have asked that we make the effort to clarify conceptually the kinds of behavior with which we are concerned—that we specify, in a theoretical and empirically meaningful way, just what it is we mean by juvenile delinquency. In my opinion, one of the reasons we have failed in our research is that we have been traveling a dead-end road in our fruitless search for simple cause and effect relationships —in our quest for factors, traits, and characteristics. I have suggested that this quest be abandoned and replaced with efforts to understand the nature of the processes that lead to delinquent careers and how these depart from and differ from processes in the careers of non-delinquents. Finally, I have asked that we recognize the need to understand those "normal" patterns and processes before we can hope to comprehend deviations from the norm.

One of the simplest criteria for distinguishing good research from bad lies in its generalizability. To be worth its salt, any research must transcend both time and space. The findings must tell us something about other cases of the same type of phenomena as those studied. It is extravagant and wasteful to dissipate our energies in the design and execution of studies of isolated problems

[21] Albert K. Cohen, *Delinquent Boys, The Culture of the Gang*, The Free Press, Glencoe, Ill., 1955, pp. 59–65.

that may be here today and gone tomorrow and may exist in only one place. Every place and time has its problems and there is an infinite number of places and times. It is imperative that the research we conduct in this area of youthful behavior and misbehavior be so designed that it will be of value the day after tomorrow as well as tomorrow and of value to people in Neighbortown as well as to those in Hometown.

THE MAKE-BELIEVE FAMILY: INFORMAL GROUP STRUCTURE AMONG INSTITUTIONALIZED DELINQUENT GIRLS

Abraham G. Novick

WRITERS ON FEMALE DELINQUENCY have been comparatively indifferent to its etiology or even to the differentiations between it and male delinquency. Professional literature has been limited primarily to a concern for the social consequences of female offenses such as prostitution or to a consideration of the care of children born out of wedlock. The tendency has been to write about the female offender in terms of the male.

The quantity of male delinquency as compared to female may be an influencing factor in determining literary attention, and its quality certainly draws society's interest. Male delinquency is largely expressed in aggressive acting-out activities such as stealing, robbery, assault, and breaking and entering. Female delinquency is expressed largely in sexual activities, running away from home, and truancy. The male offender thus tends to hurt others, while the female hurts herself. This dichotomy in self-expression along sexual lines permeates human activity at all age levels. The differences are largely due to the differences in role expectations of the boy and of the girl in our society as well as to basic variations in the psychosexual development of male and female.

Cultural Expectations of the Female

In our culture the life goal of the female is reached in marriage. In contrast to the man, who is expected to pursue a career outside the home in order to support a family and whose status is deter-

mined by the nature of his life work, woman's career centers around the home. Despite the marked increase in the number of employed married women, the worker role of woman continues to be regarded by society as secondary to that of homemaker.

The cultural atmosphere in which the girl is raised emphasizes the factors that will tend to help her reach the desired goal. She is trained to assume ladylike attitudes and behavior. Expression of aggression in the form of fighting, assault, boisterous behavior, or uncontrolled anger is taboo. She is stimulated to eschew the role of the pursuer, and wait to be pursued. Having her expectations fulfilled is dependent upon the initial moves of the girl's male counterpart. To control her environment effectively the girl, in self-defense, develops behavior patterns often regarded as deceitful, sly, and underhanded. There is a benign acceptance of these female techniques when used to control her family and to maneuver her husband into acceding to her wishes—an image well portrayed and strengthened in our mass media.

The girl's dependence upon male desires is further observed in the constant female drive for beauty. Almost from birth emphasis is placed on clothing, figure, weight control, and the effective use of cosmetic aids designed to make woman more attractive to man. This emphasis on sex is not even subliminal in our culture. The extensive development of our communication systems as public relations and advertising tools has tended to add an aphrodisiac flavor to almost all our activities and to idealize the glamorous, sexually attractive and desirable woman.

Cultural expectations are strengthened by the physical structure and biological role of woman as childbearer and mother which makes her dependent upon others during certain periods of her adult life. The relatively passive role played by the female in the sexual relationship is regarded as basic in influencing and coloring the psychosexual development of the girl. As a result, passivity, introspection, masochism, and dependency are looked upon in the psychoanalytic school of thought as female characteristics that are largely biologically determined.

Our culture tends further to differentiate the male and female roles in another area. It deems it acceptable for the female to show open affection toward a member of the same sex in the form of

kissing, embracing, holding hands, and writing endearing notes. Even the development of youthful "crushes" on members of the same sex during latency and early adolescence is acceptable for the girl and regarded as characteristic of normal female psychological development.[1] Such behavior on the part of the adolescent boy would immediately be construed as homosexual. Our society regards any open display of affection as not masculine, even in the young male child, and discourages it.

In summary, cultural expectations and, in part, physical structure, tend to: (1) foster a dependency role for the female whose life goal is achieved through marriage and child-rearing and who has strong needs to be loved, accepted, and protected; (2) force the female to develop special techniques in order to cope with her male environment; (3) place considerable emphasis on the female's narcissistic attributes in making herself attractive to the male; (4) permit the female's open expression of affection toward members of the same sex.

Peer Relationships in Adolescence

To understand the behavior of girls in a training school for delinquents, some consideration must be given to the role of peer relationships in adolescence, especially in lower-class cultures. Their influence and the roles played by the participants in sidewalk society are different from those in middle-class neighborhoods.

> The lower-class pattern of life puts a high premium on immediate physical gratification, on free expression of aggression, on spending and sharing. Cleanliness, respect for property, sexual control, achievement—highly valued by the middle class—are of lesser importance to the lower-class family. The middle-class child is encouraged and presumed to work for relatively distant goals; his parents take for granted that he will achieve these goals, and the child too comes to take his ultimate rewards for granted."[2]

Postponement of an immediate gratification for a future goal is not characteristic of persons reared in a lower-class society. The rewards and punishments of the future are too uncertain to be relied upon. Many of these youngsters are members of the most disadvantaged social groups. When they look at their own imme-

[1] Helene Deutsch, M.D., *The Psychology of Women*, Vol. 1, Grune and Stratton, New York, 1944, p. 85.

[2] Alexander H. Leighton, John A. Clausen and Robert N. Wilson (eds.), *Explorations in Social Psychiatry*, Basic Books, New York, 1957, p. 258.

diate environment with its highly deteriorated housing conditions, its doctrine of the survival of the fittest, and the lack of satisfying adult models who can inculcate middle-class values, they can find very little satisfaction in planning for a nebulous future. High mobility, overcrowded homes, the impossibility of close supervision by parents, and the high rates of adult crime tend to break down conventional social controls. It is difficult to internalize the social values of the majority in such a setting.

The lower-class female is apt to have heterosexual experience early in life. Although it is essentially true also of her middle-class delinquent sister, the etiology of the behavior is usually quite different. The activities of the adolescent girl in sidewalk society are quite acceptable to her peers and neighbors; she is regarded as delinquent only by those in the majority culture. Her behavior more often than not is a carbon copy of her mother's.

Sexual acting out by the middle-class girl tends to reflect psychological disturbance. Since sexual experience outside of marriage is taboo for the unmarried woman in our society, girls who are fighting their parents are induced to act in just this way. The behavior is a symptom of deficient and unhappy parent-child relationships, especially between child and mother. Sociocultural factors in lower-class society have produced sexual behavior patterns via normal psychological processes which are regarded as delinquent by the majority culture. In the middle-class female deviant who is fully aware of accepted values, sociocultural patterns have produced the symptom of sexual acting out by damaging her psychological processes.

In sidewalk society, status is often measured by the extent of sexual experience. More often, however, it is related to the position held by the male sexual partner in the local gang hierarchy. The girls are often organized into auxiliaries to the established gang groupings in the community. Although their functions as far as gang activities are concerned are primarily secondary, such as holding and secreting weapons, there has been some evidence of the development of girl gangs. Often these are organized along the lines followed by their male counterparts, and they even participate in similar activities. By and large, however, the role of the girl is essentially feminine in character.

The delinquent girl, no matter what the etiology of her behavior, is just as much controlled by female role expectations as is her non-delinquent counterpart. She is affected by the emphasis on glamour and is concerned about her attractiveness to the male. Sexual symbols, however, are much more prominent in the delinquent. Clothing is worn to stress sexual attributes. The use of heavy make-up and exaggerated hair-dos are common characteristics. Underneath these symbols of sophistication, however, one usually finds a little girl with strong dependency needs who is seeking love, acceptance, and protection.

The girl's failure to modify her delinquent behavior and to conform to society's dictates usually results in her being committed to an institution. Since her dependency needs are much more marked than are the boy's, the process of adjudication is often more traumatic to the girl than to her brother. She is more likely to react with hostility and hysterical outburst. She comes to the training school with an overwhelming need for acceptance often hidden by a veneer of boredom, fear, or hostility.

It has been stated that although a portion of male delinquency may be a group phenomenon, female delinquency is highly individualized. According to this school of thought, boys are more apt to be able to work as a team, maintain close group loyalties, and develop informal groupings of lasting character. The girl looks upon another of her sex as a rival rather than a team member. Her narcissism and self-indulgence make it difficult for her to work as part of a team and, therefore, she cannot be considered a good group member. This evaluation of female behavior might be correct in a coeducational atmosphere where role expectations dictate female subjection to male whims and interests. Even in coeducational colleges the tendency is for girls to play a secondary role in school activities. In women's colleges, however, the girl is not reticent about assuming an active role in student affairs. A similar reaction is seen in the girls' training school. Girls are just as status-conscious as boys, are glad to participate actively in student activities and develop their own informal groups. Informal group organization among girls has a distinct character. It differs in structure markedly from that developed among boys, but it tends to serve a similar function—despite its distinctly feminine character.

The Make-Believe Family

The informal group in the girls' institution takes the form of a make-believe family. In this grouping, the girls assume family roles—those of father, mother, children, uncles and aunts, and so on. If the structure and program of the institution and the relationship of administration to the population permit, it is possible for one girl to be lord and master of a hierarchy of family relationships. What is more likely, however, is that there will be a series of families with several girls vying for the role of kingpin. The family structure is patriarchal in that it is always the girl who plays the role of the father who determines what goes on in the group. Strictly lower-class family values are revealed in the role expectations of the group participants. The father has the right to "beat up" his wife and children, and autocratically to assign tasks and duties to family members. It is conceivable that the father will have more than one "mom," but the wife must be faithful. The father expects gifts from the other members of the family and in return gives them protection from any outside influence that might be construed as an attack. Depending upon the distance between formal and informal goals and expectations, the roles played by the girls may be either firmly structured or interchangeable. It is conceivable, for example, for a girl to play the role of a father in one family grouping and the role of a mother in another. This does not occur simultaneously but could very well do so if the institutional climate were not conducive to fully structured family play-acting.

The ritual of the informal group structure includes other features. The union of the mother and father in a family grouping may be formalized with a mock marriage in which another girl actually plays the role of preacher. The ceremony may include the presentation of a ring or it may even include the sharing of blood, a ritual in which fingers are pricked and blood exchanged. The tendency of these girls to mar themselves by carving pictures and names on their arms, legs, and thighs has been observed both in institutional and community settings. Within the institution, the carving or inking of the name of the "beloved" may become part of the informal group ritual. Secret names are assumed by the members of the group. The names are usually quite colorful and have connotations of glamour, bravery, and chivalry.

The informal group ritual also places great emphasis on note-writing and the passing of letters. The notes are messages of endearment utilizing the assumed glamour names and possessing a prescribed form and structure. One of the girls in the make-believe family usually assumes the role of messenger. This person passes notes from the writer to the receiver and may utilize considerably involved techniques to ensure their delivery. New girls coming into the institution are evaluated by members of these family groupings and are recruited into membership if found eligible from the point of view of interest in and ability to further the informal group code and procedures.

Role changes in the make-believe family, especially those of key partners, often lead to conflict. They result in a membership realignment that can be accompanied by considerable upset. So-called violence within a group of girls frequently has been portrayed in popular literature. The scene of a group of girls tearing at each other somehow appeals to the general public. It is more common, however, for upset girls to become hysterical, expressing anger by breaking objects, especially windows, or by cutting themselves. In a setting where there are highly structured informal groups, it is quite possible for the upset to spread throughout the institution thereby leading to our so-called, well-publicized, female "riots." These are not really riots; they do not have the purpose and function of male institutional riots. Female outbursts are irrational, uncontrolled, diffuse, and not goal directed.

Apart from role changes there are other conditions and factors that may trigger upsets in girls' groups. Actions or attitudes of staff members or a poor relationship with members of the informal group, especially with the girl playing the role of the father, can trigger behavior outbursts. Occasionally the girls themselves determine that it is time to "have a ball," and to break the "monotony" by consciously and formally arranging for a "breakup" at a given time.

In the past, the tendency has been to regard these activities as manifestations of homosexuality and to repress its open discussion. The failure to study the structure and function of the make-believe family because of fear and anxiety raised by the problem has often led to false accusations and occasional negative newspaper publicity.

This paper presents the hypothesis that the make-believe family in a girls' institution is the female counterpart of informal groups in boys' institutions; that the form taken by the informal group represents a structure in which basic female psychological needs can be met, according to the code of sidewalk society.

The adolescent's need for peer group relationships is well known. The peer group tends to act as a stabilizer for the adolescent faced with the conflicts of growing up in our culture.[3] Informal groups are formed within an institution because of the youngsters' needs, some of which arise from their residing within the institution. Other needs are related to the individual's personality and cultural heritage. Still another element is added in groups of delinquent girls. Dependency needs, based on physical make-up and cultural expectations, are so ingrained that the deep desire for acceptance, close friends, and protection is expressed quite openly. The girl has largely lacked any meaningful status except the status she can receive in notoriety. The informal group in the form of the make-believe family makes it possible for the dependency needs and the need for status to be met.

The nature of some of the activities of the make-believe family violates institutional discipline. If it proceeds unchecked, this informal grouping tends to prevent participation in the institutional program. Those who become full-fledged members of the make-believe family, and thereby the bearers and agents of its code and culture, have little energy or desire for participating in any other phase of the school's program. Academic, vocational, and recreational activities become fairly meaningless. The girls' listlessness and sheer boredom (noticed frequently in many institutions and at times in all) can be attributed partially to informal group influences and to the failure of administration to take cognizance of their effects or to offer substitute satisfactions.

Group Incentives

The extent to which the make-believe family will play a negative role in the institution is dependent upon the institutional climate and program and the staff's recognition of the dynamics of the

[3] George H. Grosser, "The Role of Informal Inmate Groups in Change of Values," *Children*, Vol. V, No. 1 (1958), pp. 25–29.

informal group. One technique that has been utilized in bringing about changes in informal group attitudes toward administration is the use of group incentives.

In the New York State Training School for Girls, awards in the form of dances, theater parties, and records are given to cottage units *as groups* when their members have displayed the desired patterns of behavior in the academic and vocational areas of the program. The kinds of behavior rewarded are: giving attention to school studies, obeying school rules and regulations, accepting the authority and guidance of the teacher, and similar responses indicative of a greater acceptance of the school program. Cottages lose or gain points when their constituents reject or accept these standards. If the members are to be stimulated to behave acceptably, the group awards must be meaningful and desirable to the informal group membership. When the group incentive program was inaugurated, the non-conformists, school haters, and incident perpetrators, formerly looked upon by the population with great admiration, suddenly lost their fame because they deterred their cottage units from receiving the desired awards. The so-called "squares" became important because of their ability to win points for their units. As a result, new informal leadership that incorporated more acceptable values developed in some units. In others, the old type of leadership seems to have switched gears by urging conformity to the school standards for the purpose of getting rewards, although there has been no basic change in values. There has been a marked change in the academic climate with the result that the learning and development of skills are encouraged. The incentive system has also tended to increase the cottage staff's interest in the girls' adjustment in the school area because of the desire to have a "good" and "winning" cottage. As a result there is greater co-ordination between school and cottage efforts to attain a common goal.

Institutions have largely utilized individual incentives as a means of encouraging behavior conformity. Clinical services have centered upon individual therapy sessions. Even group therapy has been highly individualistic in nature and, in many instances, has taken the form of individual therapy in a group. Clinical services for individuals seem to have a limited effect upon the informal group

structure. It is quite possible to wean a girl away from informal group contact through the relationship established between the girl and her therapist, counselor, or cottage parent. Such a girl, however, tends to become an isolate. She joins a number of other youngsters who steer clear of informal group involvement because they feel that it will mean trouble and will influence the speed with which they can return to their communities.

Group incentives seem to be particularly meaningful to lower-class girls whose delinquent behavior has been produced by sociocultural patterns via normal psychological processes. When the delinquency is a symptom of a deeper disturbance, the response to group incentives is often much less favorable. In fact, in some girls, the need for punishment tends to increase their nonconformity. Girls with masochistic tendencies also tend to respond negatively. Prepsychotic girls and youngsters with a rich fantasy make-up tend to respond to their own psychological urges and needs rather than to group incentives. However, since the vast majority of girls who come to training schools fall into the category of social delinquents, especially when the school serves a large metropolitan area, group incentives apparently can play an important role in encouraging acceptable behavior patterns.

The psychologically disturbed delinquent can adjust better in a small facility where considerable individual attention can be offered. The New York State Training School for Girls now has available a branch facility where girls of this type can be sent for treatment. Another branch facility is being planned which will accept a still more disturbed group of delinquents from the main institution, who require security as well as more individualized treatment.

Program Activity and Group Content

What activities can be fostered within the institution that can command interest equal to that of the make-believe family? What sublimatory activities can be developed to aid the internalization of socially accepted values and goals? This problem is more easily solved for boys than for girls. Boys are more work-oriented. The adult goals, learning to make a living and to support a family, make adolescence much more a preparatory period for the boy than for the girl. The tendency to plan activities in girls' schools

in the same manner as in boys' schools fails to take into account the uniqueness of female goals and aspirations. To the girl who has been raised in sidewalk society, career preparation is often regarded as a ridiculous pastime. As soon as she reaches puberty school becomes intolerable. The compulsory attendance law becomes a hindrance to the immediate gratifications provided by street life and she is apt to break it frequently. She looks upon herself as a full-grown woman capable of establishing herself apart from her family.

It is possible to stimulate the interest of girls in activities such as beauty culture, sewing, home economics, typing, shorthand, nursing, millinery and ladies' handbag manufacturing, and so on. It is equally possible to have many girls respond well in academic subjects. These activities, however, should not be regarded necessarily as preparation for a career, although this can be a logical outcome for some girls. They should be considered opportunities for the development of skills and interests, and thereby, an aid in raising the girl's self-esteem.

Dramatics and interpretive dancing are activities that cater directly to the narcissistic make-up of the delinquent girl. They are excellent media for self-expression. In fact, the dance in all forms probably should replace the typical gymnastic and physical education program for girls. The dance offers the girl the opportunity of demonstrating grace in movement and of focusing public attention on her figure and bodily attributes in a socially accepted manner. Dramatics allow for approved play-acting, an important attribute of the make-believe family. Other sublimatory activities that permit socially acceptable exhibitionism include choral groups, oratorical contests, charm groups, water ballet, rhythm marching units, and similar projects. Girls also respond to religious programs. Religious activities tend to meet dependency needs, while Easter plays, Christmas pageants and other types of religious dramatic production seem to foster a temporary identification with the roles played. "I feel cleansed" is often the girl's response to participation in a religious activity.

These activities are not only sublimatory in nature. They also tend to redirect the program content of the informal group system so that the girls rely less on negative and destructive activities

to further the purposes of the peer groups. They learn to secure similar satisfactions with possibly the same informal peer relationships but through socially accepted channels.

Staff-Child Relationships

The need for close and meaningful relationships between staff and girls has been long accepted in the institutional field. No progress can be made in a punitive atmosphere. A close relationship between a staff member and a girl, however, does not mean that the social distance between the two is lessened. The vast difference in status betwen girl population on the one hand and administration on the other encourages hostile informal group activities. To narrow the gap between the two groups, techniques must be devised to raise the status and self-esteem of the girls.

The establishment of cottage councils in each living unit—where girls and staff together can discuss problems, plan activities, establish a few ground rules of behavior, and identify, assume, and assign work responsibilities—offers a vehicle for the desired group interaction. Permitting girls to have a voice in their own affairs with staff acceptance, encouragement, direction, and participation is therapeutic and educational. To most girls this is a new and highly satisfying experience. They become much more oriented to the function and purpose of the school program. They have the opportunity of discussing and sharing some of their problems. Programs that have been initiated with the girls' participation are more readily accepted by the group through the mobilization of informal group controls.

Another element that affects the informal group structure is present in the girl-staff relationship. Staff members are apt to become concerned about the make-believe family, and to regard its activities as homosexual in nature. Strong feelings of anxiety are raised which are often handled through punitive action. Such an approach only strengthens the make-believe family as an anti-staff tool. Punishment increases the status of the girl within the informal group. She may receive the support of her friends which can lead to greater unrest within the unit. This may very well be the result, if the girl who plays the role of the father is disciplined. Staff anxiety also makes the girls' activities seem more daring, secretive, and glamorous.

When staff members understand the dynamics of the informal group they can use certain positive techniques which result in breaking down the role structure of the make-believe family. Reality then seems to gain ascendancy over play-acting for many girls. Others tend to share their secrets with staff members so that the latter are informed well in advance of any planned destructive activities, often by the leaders themselves.

Staff development programs that enhance the employee's ability to cope with the dynamics of group life within the institution should be encouraged. At the New York State Training School for Girls clinically-trained personnel supervise the cottage staff so that the day-to-day consultation and professional support that are required for a treatment-oriented program can be provided.[4] This plan fosters an integrated team approach in working with delinquents and prevents the playing of one staff member against another. It also offers an organizational structure that is uniquely designed to focus on and influence the informal as well as the formal group behavior of the girls.

Coeducational Activities

The statement is often made that coeducational activities or even a coeducational school would tend to eliminate the make-believe family. This point of view utterly fails to take into account the dynamics of female informal group structure. It implies that the make-believe family is only a product of an all girl environment that offers a homosexual medium for meeting sexual drives. I do not concur with this point of view. Coeducational activities, such as dances and parties and the use of male personnel, should be encouraged. Although these procedures make for a more normal climate and do have therapeutic connotations, they do not automatically eliminate the make-believe family.

Conclusions

Female psychology and cultural expectations in our society determine the manner in which female delinquency is to be expressed.

[4] See Abraham G. Novick, "Classification and Treatment," *NPPA Journal*, Vol. IV, No. 1 (1958), pp. 34–42; also Lloyd E. Ohlin, "The Reduction of Role Conflict in Institutional Staff," *Children*, Vol. V, No. 2 (1958), pp. 65–69.

Recognition must be given to the fact that the dynamics of such behavior are decidedly different from the dynamics of boys' behavior, and we should therefore stop defining all delinquent behavior in terms of the male.

In the correctional institution the female counterpart to the male informal group is the make-believe family. This grouping is peculiarly suited to meet strongly ingrained dependency needs and the temporary aspirations of delinquent girls. If its negative aspects as a repository for delinquent values are to be reduced, and if the girls are to be motivated toward achieving positive goals, highly individualized procedures should be replaced by greater use of group methods. These include the use of group incentives, program content that focuses on activities that can sublimate the girls' narcissistic and exhibitionistic tendencies, and the use of techniques that will lessen the social gap between staff and girls.

The make-believe family is anxiety producing for staff members and can lead to their making punitive attempts to eradicate it. These attempts will not succeed. Punishment only intensifies and solidifies its anti-staff function. Positive approaches can be used to mobilize informal group leaders to accept the formal goals set by the institution. Such approaches do not ignore the existence of the make-believe family but rather utilize it as a treatment force in changing delinquent values.

EGO FACTORS IN THE SEPARATION OF UNWED MOTHER AND CHILD

Harry G. Gianakon, M.D.

THE QUEST FOR CERTAINTY in intrapsychic and interpersonal matters is as ancient as consciousness. Among those who attempt to serve the unwed mother the longing for certainty may be expressed in two basic questions which are their daily challenge: (1) How can the unwed mother be most effectively helped to anticipate and accept separation from her socially stigmatized infant? (2) At what exact and certain moment should the separation be accomplished?

All civilized human beings sense the profound depths of these simple queries. It is not enough, in our modern time, to be guided merely by the injunction, "Do no harm," which sometimes in the past has guided those who offered help. In addition, modern workers must motivate and enrich the lives entrusted to them for assistance, so that future harm may be rationally prevented and physical and emotional maturation may proceed. Little wonder that certainty is so feverishly pursued!

Yet, accumulated wisdom and experience testify that there is no certainty—except "death and taxes," as we are frequently reminded. Leo Kanner [1] admonishes all who work with children and mothers to avoid the pitfalls of Procrustean medicine. Although Procrustes, you will recall, was not a medical practitioner but the proprietor of an inn, he had a strong sense of certainty—as wayfarers could testify who had been fitted to the harsh requirements of his hospitality. But, if certainty can be won only at a terrible

[1] Leo Kanner, *A Word to Parents About Mental Hygiene,* University of Wisconsin Press, Madison, 1957.

price, where are we to find the strength and understanding to answer the questions that are so pressing and demanding? They can be found only in the accumulation of certain knowledge and in the employment of that certain knowledge to increase our rational and scientific mastery over the uncertainties, inward and outward, that beset patients and professional workers alike.

Dependency Needs of the Mother

There is available a great deal of certain knowledge that can be useful in determining methods of helping the unwed mother in the process of separating from her child. It is known that all her actions and decisions will be based on her biological need to be loved. Animal researchers and experimenters are documenting and verifying the animal organism's vital instinct to love and be loved. In order to gain the courage to explore the environment and to develop new patterns of behavior, monkeys must possess the certain knowledge that they can cling to, love, and feel loved by a constant love object—even if it is but a piece of cloth.[2] The unwed mother, like all of us, has these same instincts. Her unsuccessful search for love and approval and the lack of gratification of her dependency needs have evoked the behavior that has resulted in her predicament.

Of course, the search has been destructive to the fulfilment of her desires precisely because the true, real, basic needs that so desperately drive her have been unconscious. The unwed mother has been stripped of the greatest human gift—rational thought—in finding effective solutions for her needs by the very fact that those needs have been exerting their influence in unconscious, irrational, and reality-alien ways.

These irrational forces continue to impede and frustrate her recognition of the realities that must be faced, and block the development of new patterns of thought and feeling that must evolve if further emotional, physical, and social traumata are to be prevented. One of the unwed mothers at the Florence Crittenton Home in Philadelphia spent her every waking moment wondering whether the males in the neighborhood of the Home knew all about her

[2] H. F. Harlow and R. R. Zimmermann, "Affectional Responses in the Infant Monkey," *Science*, Vol. CXXX, No. 3373 (1959), pp. 421–432.

case and what they thought about it. She was so alert to the glance of every passing male and so sensitive to his every gesture that she had no energy to devote to the serious reality surrounding her and to the grave decisions that had to be made. All her questions to the professional workers who were trying to help her had to do with concerns that had no real relation to the problems that clamored for rational thought and mature decision. She continued to attempt to solve her problems and satisfy her needs through the old means of denying realities, projecting disturbing feelings and urges onto others, stripping herself of the intelligence and reason that were imperative in the circumstance. Only as the professional workers could recognize her tremendous basic needs and could show her new ways of gratifying them, could she begin to learn and adopt new ways.

So, it is certain knowledge that the unwed mother will learn and adapt only as she begins to recognize within herself the universal needs of dependency and love, and discovers that they are recognized and accepted by those to whom she turns for assistance. But just as certain is the knowledge that each unwed mother is a unique phenomenon. Each mother is different from any other personality past or present. Careful, scientific study of her unique personal expression of the universal, animal, and human desire for love must be conducted. Psychiatric and psychologic orientation of all professional staff serving the unwed mother is mandatory. Psychiatric consultation and a psychologic assessment of each unwed mother are basic requirements in an enlightened institution.

In the overwhelming majority of instances, the actual delivery of the infant, with the mother's prospect of separation from it, will be an anxiety-producing experience. Freud reported the certain knowledge of how to manage anxiety successfully: (1) the anxiety must not be surprising and overwhelming in its reality aspects; (2) irrational and neurotic methods of attempting to handle the anxiety must be replaced by rational and ego-directed actions; and, (3) there must be opportunity for repetitively "working through" the anxiety-producing experience until psychic mastery is gained over it.[3]

[3] Sigmund Freud, *The Problem of Anxiety*, W. W. Norton & Company, New York, 1936. Sigmund Freud, *Beyond the Pleasure Principle*, Liveright Publishing Corp., New York, 1950.

Roughly and briefly translated to our present concern, it would seem that the goal of minimizing the emotional and physical damage to the unwed mother can be accomplished by adhering to these principles in the following way. (1) Planning for the details of delivery and care and for the separation of mother and baby should begin as early as possible. Just as hospital and obstetrical procedures are discussed and shared with the mother, so also must be shared the emotional factors that affect her attitude and the details about placement plans for the infant. If she has opportunity to question and explore every possible vicissitude, the final experience will be robbed of much of its terror and overwhelming surprise. (2) Through proper assessment and understanding of the personality and social facts in the individual case, the professional worker can assist the unwed mother to give up the frightening, infantile, and neurotic defense operations and help her to employ her reasoning and intelligence in an atmosphere of kindliness, tolerance, and helpful acceptance. (3) Just as, in an obstetrical sense, there must be "after care," so it is necessary that the mother be allowed to "work through" the emotional residues of the experience, in order that she may gain some degree of mastery over her feeling of loss and deprivation of that living part of herself, the baby.

Effects of Separation on the Baby

What of the baby? Can he withstand separation without lasting damage, and at what moment must the separation be accomplished? Once again, there is no definite answer, but a body of certain knowledge has been gathered and continues to grow. Separation is an intrinsic characteristic of living matter. It is certain knowledge that conception cannot be realized until the ovum ruptures and separates from the ovary and fuses with the spermatozoid cell, which has separated from the male body. The fertilized ovum cell is known to be alive by the fact, observable under the microscope, that it continues to separate and to produce two cells where one was, before; the two cells produce four, and so on. As the growth of the fetus progresses, it demonstrates another principle of separation (and life): that separation proceeds in convulsive, spasmodic, rhythmic sequences. Sometimes it is very rapid; at other times it proceeds slowly, almost imperceptibly. Too rapid separation at cer-

tain periods leads to biological damage of the organism. Thus, Shakespeare's Richard the Third exclaims:

> Deform'd, unfinish'd, sent before my time
> Into this breathing world, scarce half made up,
> And that so lamely and unfashionable
> That dogs bark at me, as I halt by them; . . .

On the other hand, sudden separation, such as occurs at the instant of birth, can be a proper and natural circumstance. From this, it is possible to conceptualize the principle that intervention in the separation can be successfully introduced at certain times but not at other times.

Psychologically the goal is also separation—the gradual separation of mother and infant—so that two identities and personalities will evolve where only one was. But this psychological separation also occurs in spasms and convulsions. Olson [4] speaks of the "unfolding design" of the personality and concludes that at various times the design unfolds swiftly, and at other times moderately or slowly.

There was a time when it was considered sound to delay separation until the baby could be tested—toward the end of the first year of life—in order that his intelligence and psychobiological integrity could be measured and assured. Spitz [5] and Bowlby [6] discovered that such a delay in placement with a constant, maternal figure might damage the child's ability to form meaningful relationships, and full personality growth would be stunted and marred. Advanced agency policy and practice have reflected this newfound knowledge, and separation and placement have taken place at an increasingly early point.

But how early should this be? Hartmann, Kris, and Loewenstein [7] termed the first three months the "undifferentiated stage," and some belief exists that at least this much time is needed to carry out sound placement plans. Not much seems to be happening; ". . . the organism functions according to the Nirvana principle; it seeks

[4] W. C. Olson, *Child Development*, D. C. Heath & Company, Boston, 1949.

[5] René A. Spitz, M.D., "Emotional Growth in the First Year," *Child Study*, Vol. XXIV, No. 3 (1947), p. 68.

[6] John Bowlby, M.D., *Maternal Care and Mental Health*, World Health Organization, Monograph Series No. 2, Geneva, 1951.

[7] Heinz Hartmann, M.D., Ernst Kris, Ph.D., and Rudolph M. Loewenstein, M.D., "Comments on the Formation of Psychic Structure" in *The Psychoanalytic Study of the Child*, Vol. II, International Universities Press, New York, 1946, pp. 11–38.

tension reduction. In the following weeks, responses in terms of the pleasure-unpleasure principle are developed. As yet there is no differentiation, either in perception or in memory, beyond the rudiments necessary to establish elementary conditioned reflexes." [8]

Sontag [9] and his workers have demonstrated that "elementary conditioned reflexes" begin *in utero*. Their experiments indicate that the well developed fetus can be conditioned. For example, the older fetus can learn to respond to tappings and scratchings on the mother's abdominal wall. In other words, the baby's whole psychobiological system must be learning how to adjust to the biological, hormonal, physiological rhythm of his mother, even before delivery. He is already beginning to build up a very primitive concept of the way she functions, the way she feels, and the way she regulates the tension and stress within her body. We must hypothesize that the infant's regulatory mechanisms are slowly and imperceptibly being tuned to the maternal vibrations which will be the basic foundation on which the relationship will grow after delivery.

Ribble [10] points out that, once the infant is born, his regulatory mechanisms—which adjust his body temperature, determine his breathing patterns, and adapt his cardiovascular system—are dependent on the intimate, close relationship with the mother figure. The maternal figure's chief function during this earliest stage is to provide a constant and loving atmosphere and physical contact, which are essential if the infant is even going to breathe correctly or adapt in the most primitive way to the world into which he has been born.

Conclusion

Surely, these happenings are little things. But they occur during the time when the first building blocks of the personality are being set. All that comes later will be based upon this foundation; personality and life are based on little things. We know that the living cells of the human body are constantly changing. Our nails grow,

[8] René A. Spitz, M.D., *A Genetic Field Theory of Ego Formation—Its Implications for Pathology*, International Universities Press, New York, 1959, p. 16.
[9] L. W. Sontag, "Differences in Modifiability of Fetal Behavior and Physiology," *Psychosomatic Medicine*, Vol. VI, No. 2 (1944), pp. 151–154.
[10] Margaret A. Ribble, *The Rights of Infants; Early Psychological Needs and Their Satisfaction*, Columbia University Press, New York, 1943.

our hair grows, our entire epidermis sheds, so that we are really never the same person, biologically, we were an instant ago. Psychologically, the process is the same, as the study of dreams reveals. One of the constant sources of dreams is "invariably the events of the preceding day" and these impressions are composed of "indifferent" and unimportant perceptions.[11] Biologically, we change through very slight and imperceptible cell divisions; psychologically, we change through the acquisition of new symbols from immediate and indifferent perceptions.

Certain knowledge dictates that, ideally, the baby should be cared for by the mother who has borne him. Their separation, at all, is unnatural and can never be a harmonious and happy event. The least that can be done is to ensure that the decision for separation be made early, as far in advance of the delivery date as possible. When the natural mother's decision is made, she can be helped to reach a state of psychological homeostasis and equilibrium, which will be reflected in her regulatory mechanism patterns and will have a stabilizing effect on the developing fetus. Then, after delivery, the infant should be placed, as soon as possible, in the hands and care of the mother figure who will help him mold his individual personality and fulfil his human destiny.

Lest all these comments begin to seem like certainty, let us recall that we have not mentioned the personality survey and preparation of the adoptive mother; the collaboration of maternal care and placement agencies; the co-operation of obstetrician, pediatrician, and hospital nurse personnel; the involvement of the unwed mother's family, and so on. There can be only this certainty: that no certainty exists and that the task of ameliorating the separation of the natural mother and her child calls for the toleration of uncertainty, however great. It is the responsibility of all professional workers in this field to continue to investigate and record and share their experiences. In this way an increasing body of certain knowledge can become available to all the workers who are faced with accepting what appears to be a tragic and bitter event and creating from it a new and more hopeful world for mother and child.

[11] Sigmund Freud, *Interpretation of Dreams,* Standard Edition, Vol. V, Macmillan Co., New York, 1953.

OUT-OF-WEDLOCK PREGNANCY IN ADOLESCENCE

Marcel Heiman, M.D.

There is a history in all men's lives,
Figuring the nature of the times deceased;
The which observ'd, a man may prophesy,
With a near aim, of the main chance of things
As yet not come to life, which in their seeds
And weak beginnings lie intreasured.
Such things become the hatch and brood of time;
—William Shakespeare
Henry IV, Part 2 (Act III, Scene 1)

WHEN WE STUDY the history of out-of-wedlock pregnancy in order to "prophesy with a near aim, . . . the main chance of things" to come in the next ten years, our interest will be not only in the statistics—the increase or decrease in the numbers of out-of-wedlock pregnancies—but also in giving meaning to these statistics. We shall want to know *why* these things will happen. The sociologist and anthropologist will look at out-of-wedlock pregnancy from a point of view different from that of the psychoanalyst. The psychoanalyst will not overlook the social, economic, or cultural factors, but neither will he concentrate on them. He will concentrate on the personal "history in all men's lives."

We are far from satisfied with what we know of the dynamics of out-of-wedlock pregnancy and the motivations of the unwed mother, but a beginning has been made. What we have learned promises to be of real use to us in the coming decade. It may well be that our understanding of the dynamics of out-of-wedlock pregnancy will be more applicable to the treatment of the individual unwed mother

than it will be to our efforts to prevent out-of-wedlock pregnancy. The same holds true for emotional disturbances in general: we can understand them more easily than we can cure them, and we can cure them more easily than we can prevent them.

The Scope of the Problem

A United States Public Health Service report for 1957 reveals that among females above the age of 14, the largest percentage of out-of-wedlock births occurs in the 15- to 19-year-old group.[1] This percentage is greater than that in any other five-year period of the female's reproductive life. This pinnacle of approximately 39 per cent of all out-of-wedlock births is, incidentally, almost identical for both the white and non-white population. Furthermore, the *increase* in out-of-wedlock births during recent years has occurred primarily within this same age group. These figures emphasize that the highest percentage of out-of-wedlock births occurs during what are still the girl's formative years—adolescence and the late teens. From all indications, there will be a further increase in the coming decade. Information from the Public Health Service shows, for the 35 states reporting, an increase from 201,000 in 1957 to 208,000 in 1958.[2] At this point, I should like to express a thought about the anticipated increase in out-of-wedlock pregnancies, without elaborating upon it. We are well on the way to understanding how both emotional and somatic illnesses may be reactions to grief and depression. As medicine and science advance in the fight against bacterial and viral agents and in coping with malignancy, there will be a decrease in somatic illness. This decrease in somatic illness will inevitably bring in its wake, I believe, an increase in behavioral problems and emotional illness, including out-of-wedlock pregnancy.

Out-of-wedlock pregnancy defies a simple explanation because it means so many different things to so many people. This is true not only for Warwick's "the which observed," the unmarried mother herself, but for those of us who are the observers. What are we

[1] *Vital Statistics of the United States: 1957. Volume I,* U. S. Department of Health, Education and Welfare, Public Health Service, National Office of Vital Statistics, p. LXXXIV, Table BQ.
[2] Personal communication.

to make of this peculiar behavior? It is not a neurosis, not a psychosis, not psychopathy, and not a psychosomatic disorder—although it may be one aspect of any of these. It is at one and the same time an expression of biological creativity, of neurotic acting out, and of delinquency. Out-of-wedlock pregnancy could be called a doomed-to-failure rebellion of the immature. The young woman is like the fly caught in the web of the spider. As she struggles to free herself she becomes all the more thoroughly entangled. More often than not, she ends up closer to her mother than ever before—exactly what she aimed for, unconsciously.

Sometimes it appears that the woman is using her own body, particularly her reproductive organs, as the tool with which to hurt herself. Obviously, out-of-wedlock pregnancy must be studied if it is to be understood. One might expect that their very training would prepare psychiatrists and social workers to understand out-of-wedlock pregnancy, but this is not so, although the study of out-of-wedlock pregnancy brings us close to the whole range of human psychopathology.

The Feeling of Omnipotence

Over the past three hundred years a series of revolutions in man's knowledge of his place in the universe have little by little reduced our feelings of importance. First, the astronomers showed us that the earth is not the center of the universe; then Darwin made it clear that man is not in a class by himself but is, rather, a part of the animal kingdom—a human animal. Having survived these painful revolutions in our thinking, we were faced with yet another, and perhaps the hardest blow of all. Freud taught us the importance of the unconscious and with it the inevitable lesson that we are not even our own masters but have to reckon with unconscious needs and wishes of which—by definition—we are not aware.

Having thus been reduced by degrees to an insignificance to which human megalomania cannot resign itself, we now find ourselves in another revolution—that of the technical sciences—but this is a counter-revolution. The push-button kitchen, the automation of industry, and the speed and forms of modern communication have unhappily restored to us our feelings of mastery and of omnipotence. What we attempted to do in the past, with the help of magic and

superstition, is now being achieved through science. There is more magic in present-day science than there ever was in magic itself.

Man's advances in science are not *aimed* at regaining his lost position in the center of the world, but they can be used for just that purpose. More than anything else, the timing of this technical revolution is unfortunate. At a time when the insights gained in thousands of years of religious and spiritual search for that final goal—"Know thyself" (and, thereby, *control yourself*)—have been complemented by psychological understanding, man again sees himself as master of his world, and he detaches himself from it!

Loss of Inner Control

I should like to examine one particular question: How are inadequately applied controls related to biological creativity, neurotic acting out, and delinquent behavior as found in out-of-wedlock pregnancy? Although it is an oversimplification, it can be said that a feeling of greater control over the external world goes hand in hand with a decrease in the need for self-control. Not even that most perfect of timing devices, the blast-off mechanism of a rocket, will ever be a substitute for the self-control of our instincts.

How is the idea that there is a relationship between control of the outer world and control of one's inner self applicable to the phenomenon of out-of-wedlock pregnancy?

It should be remembered that the adolescent girl, particularly the one who is pregnant out of wedlock, has to cope with an increase in her need to be omnipotent and a decrease in her ability to control instinctual demands. Moreover, there is a complex interaction within the family of which we see only the gross manifestation—the pregnant girl.

Out-of-wedlock pregnancy should be looked upon as a means by which the girl tries to prove that she is in control.[3] When a certain attitude on the part of the girl's mother interferes too strongly with the girl's fantasy of having omnipotent control over the mother (the love object), the girl re-establishes a feeling of omnipotence by creating the lost love object by herself, and within herself, through pregnancy.

[3] Marcel Heiman, M.D., and Esther G. Levitt, "The Role of Separation and Depression in Out-of-Wedlock Pregnancy," *American Journal of Orthopsychiatry*, Vol. XXX, No. 1 (1960), pp. 166–174.

According to our understanding of personality development, parental discipline or control is internalized and becomes part of the superego, the individual's ally in the control of his instinctual wishes. No better theory has been brought forward to advance our understanding of the development of conscience. But what happens if something goes awry with parental discipline and control? Only a parent who has a well-functioning, that is, well-integrated, personality structure can give the kind of firm, consistent discipline which, when internalized by the child, can become the nucleus of his self-control. Defects or deviations within the psychological structure of the parent are likely to find expression in the faulty development of the child. Certainly, a lack of discipline by the parent may well lead to a lack of self-control within the child.

Lack of parental discipline does not always lead to out-of-wedlock pregnancy. Sexual promiscuity, drug-addiction, alcoholism, delinquency, and a host of other difficulties may also be the result of inadequate discipline. Faulty parental influence is not always clearly apparent; at times, it may be concealed behind a front of respectability or pious protestations.

Impact of Family Members

Out-of-wedlock pregnancy is an expression of both intrapsychic and interpersonal conflict. It may be the expression of a neurotic or psychotic disturbance. In addition, it is an expression of the girl's conflict with her immediate environment (her family) and the wider environment (the cultural setting in which she lives). Without losing sight of the intrapsychic conflict, I should like to emphasize out-of-wedlock pregnancy as a phenomenon brought about by conscious and unconscious forces which are brought to bear upon the girl by members of her family, for the most part by her mother and father. It has been my observation that in most instances in which the out-of-wedlock mother had difficulty in giving up her child, it was because her own mother wanted to keep the child. At times it was her own mother who wanted to bear the child in the first place.

In my opinion, in the next ten years we shall come to look upon out-of-wedlock pregnancy as the result of family pathology. This shift in focus will take place as we penetrate more deeply into the

motivations for becoming pregnant out of wedlock; particularly as we recognize the role of other persons in the family group who pull the marionette strings to which the girl is unconsciously attached. In addition to studying and understanding out-of-wedlock pregnancy from the point of view of the unwed mother, we shall also have to study the psychology of her parents. Such examination will doubtless reveal the extent of their unconscious participation in creating the situation in which the daughter is caught.

Helping the unwed, pregnant teen-ager find a wholesome solution is not an end in itself; it is but the first step in a total process of rehabilitation. The dilemma of the social worker (usually a woman) confronted with a young client who is pregnant out of wedlock is obviously complex. If she considers that out-of-wedlock pregnancy is the act of a social outcast, for therapeutic purposes she will ally herself with the girl; if she considers it the expression of a neurotic conflict, she will help the girl work through her conflict; if she considers it the result of acting out, she will try to help the client achieve insight into her motivations.

All these treatment approaches are well intentioned, but unfortunately they are also hopelessly impractical. They fail to take into consideration the essential role of the social worker—the genuine protection of the human being (in this case the two human beings) under her care. In dealing with out-of-wedlock pregnancy both therapeutically and prophylactically, the caseworker must be guided by her recognition that out-of-wedlock pregnancy is, in many instances, as much a product of family psychopathology as of the female's own. Any agency that deals with the problem of out-of-wedlock pregnancy should make the family as a unit the focus of casework treatment, if it is to cope adequately with the expected increase in the caseload. This means that the agency that serves the unmarried mother must function as a family agency.

The interaction pattern within the family of a girl pregnant out of wedlock, especially between the girl and her parents, is extremely complicated. Moreover, defective parental discipline has served to hinder the development of the girl's inner controls. The caseworker must then be decisive, firm, and unswerving in her pursuit of a healthy solution for the girl's problem. The "I'm going to help you by standing by while you work it through" approach will not do.

What is expected from the worker is precisely what the child expected but did not get from her parents—a decisive "No!" It is essential that the parent most involved, psychologically, in the daughter's pregnancy also be dealt with in a manner identical with the one suggested in dealing with the girl. Time is of the essence; the maturation of the fetus proceeds at an inexorable pace. An ambivalent mother, interfering with her daughter's ability to arrive at the decision to surrender her child, must be dealt with as though she (the girl's mother) were a child herself.

It has been my observation that there is a direct relationship between the severity of a girl's emotional disturbance and her inability to surrender her child. The sicker the out-of-wedlock mother, the greater her need to hold on to the child, for unhealthy reasons. The child's chances for healthy development are poor indeed with such a mother. Therefore, society should not only protect the mother's right to her child but also protect the child's inalienable right to develop into a healthy human being.

Severe degrees of individual psychopathology are almost always present when there is severe family pathology. For this reason, family members should be the focus of treatment from the very point at which the girl comes to an agency for help. Moreover, the family members must be treated with the same firmness that the worker must use in helping the girl arrive at a healthy solution.

The prevention of out-of-wedlock pregnancy must be based on the same general principle involved in preventing in-wedlock pregnancy—sexual abstinence. I believe that it is unwise to instruct the young teen-ager in the use of contraceptives. Such instruction only serves as encouragement and license.

Case Illustrations

I should like to cite a few illustrations that highlight the problems of the girl pregnant out of wedlock.

Case 1: Maureen, a borderline psychotic girl with paranoid tendencies, became pregnant shortly after her seventeenth birthday. Her overt difficulties had begun when she was in her early teens. By the time of her pregnancy she had repeatedly truanted from school, run away from home, and engaged in shoplifting. She had been brought before the Children's Court, had twice been admitted

to a mental hospital, had been known to a family agency and a private psychiatrist, and had run away from a residential treatment institution. She used the vilest language I have ever heard, chiefly when talking about her mother. Her father had died while serving in the armed forces, when Maureen was between two and three years of age. Her mother had remarried soon after. Her mother had had another child, delivered by Caesarean section, and had been advised against further child-bearing. Maureen not only knew that her mother used this medical advice to justify her refusal to have intercourse with her husband, but had also been told by her mother that her stepfather went to brothels.

I recognized Maureen as an undisciplined, uncontrolled, and uncontrollable girl. There was considerable evidence that Maureen's mother had played a major part in Maureen's problems. Her mother had encouraged Maureen's provocative behavior, such as dyeing her hair red (like her mother's) and wearing elaborate earrings. She had also helped Maureen and the putative father to run away, and had given Maureen money for the trip. When it came time for the final surrender of the baby, it was her mother who influenced Maureen against this step.

Case 2: Laurie came to the agency at the age of 23, pregnant for the second time. The putative father was of another race. Her contact with the agency at this time gave us an opportunity to understand the circumstances surrounding her first pregnancy. She had delivered that baby when she was 15 years of age. Her father had made the arrangements for the baby's adoption in a private placement.

Laurie's father could be described as a "charming heel," who had not worked for many years. It was for this reason that Laurie's mother had divorced him when Laurie was about 12 or 13. At the time of the divorce, Mr. B had been going with a woman twenty years younger for some time, and he married her when Laurie was 15, (the age at which she became pregnant for the first time). Laurie's father had taken an inordinate interest in her during the first pregnancy, something he had never done before. He had secreted her in another state and had then arranged for the baby's adoption. The significance of this case lies not in the oedipal acting out by the girl, but in the parent's participation in the acting out.

Case 3: Rhoda came to the agency when she was 24 years of age. This was her third out-of-wedlock pregnancy. Both the other pregnancies had occurred in her teens. They had been terminated by abortion.

When Rhoda was 5 years old a brother was born. Her father had reacted to this birth by leaving to take out-of-town jobs. He was home only on weekends. He had become cold and undemonstrative toward her. Her search for a father, as she had known him when she was a little girl, had ended some years previously when she had found a man, 21 years her senior, who had become her "sugar daddy." He had been responsible for the first two pregnancies.

One can see how her father's behavior promoted Rhoda's acting out. But perhaps more disturbing to Rhoda was her mother's part in her difficulties. When Rhoda had first come to the agency she had been accompanied by a woman who identified herself as Rhoda's aunt but who turned out to be her mother. So much did her mother consider Rhoda's baby her own that Rhoda felt she was not giving up her own baby, but really her mother's baby. Rhoda's younger brother was just leaving home for college and Rhoda said that "mother needs the baby as a replacement for him."

In this case, the thesis offered in this paper—that the out-of-wedlock pregnant girl uses her own body as an instrument—is taken one step further. The mother uses the daughter's body to provide her (the mother) with a substitute for a love object she is losing.

Case 4: Anne conceived at the age of 14, at the time her mother gave birth to a baby girl. By chance, Anne's parents were in contact with a family agency at the time Anne was seeking help from another agency with her out-of-wedlock pregnancy. Consultations between the social workers of the two agencies made more information available than is ordinarily available when an agency deals with the parents only peripherally.

In this family, fighting and abusive language were the "order of the day." Anne's relationship with her father was openly sadomasochistic. From the time she was 11 and had become interested in boys her father had beaten her mercilessly, once even breaking her thumb. In addition, her father clung to the mother and to Anne like a phobic child. Some of the worst scenes occurred when

the mother wanted to go to her weekly card games. Since the father could not beat the mother, he would beat Anne, but for the same reason—leaving him.

Anne started to have asthma (like her father) between the ages of 7 and 8. Whenever her mother would leave the house and Anne was left alone with her father, she would have an asthmatic attack, accompanied by an intense fear of choking to death. Anne knew that her mother was frigid and did not care for intercourse. Her mother's leaving Anne alone with her father was felt by Anne as a withdrawal of her mother's protection against a sexual attack by her father. An asthmatic attack was the result.

This case is a good example of a girl who is not too severely disturbed emotionally but whose chances for healthy development are poor while she remains within her family circle. Understanding each of her parents' difficulties is essential in planning for Anne's future.

Summary

In summary, it can be said that man's increasing mastery over machines and matter is serving to conceal the inadequacy of his inner controls. The instinctual controls of the child have been weakened by the lessening of parental discipline. Out-of-wedlock pregnancy should be viewed as one expression of the loss of inner control. When a social worker tries to help a teen-ager who is pregnant out of wedlock, the focus of attention should be the girl's family rather than the girl herself. When this is true, we shall witness changes in our therapeutic approach which may lead to adequate prophylactic measures.

EXAMINATION OF SERVICES TO THE UNMARRIED MOTHER IN RELATION TO AGE OF ADOPTION PLACEMENT OF THE BABY

Mary Lynch Crockett

TODAY, THE UNMARRIED MOTHER is receiving more attention and service from social agencies than ever before. The quality of service is assuming a different character as new and deeper knowledge and understanding of the forces that bring a person into the unhappy situation of unwed parenthood have radically challenged the casework approach to the problem. In many agencies there is genuine recognition that the unmarried mother needs to be considered as an individual, that help must be an all inclusive service, with the planning for the child only one part of the whole, and that the ultimate goal is to help her become at peace with herself and a happier person.[1]

Within the last ten years, it has become generally accepted that delaying the placement of the infant, until the results of psychological tests can be interpreted with certainty, cannot be justified. An early decision regarding an adoptive placement has distinct advantages both for the natural mother and the child, as well as the adoptive parents. Every effort should be made to place the child for adoption as young as possible, after the natural mother's parental rights have been terminated. The only circumstances under which delay is justified are those in which the mother's emotional state indicates that she is so unstable that a caseworker needs to validate

[1] Ner Littner, M.D., "The Natural Parents," *A Study of Adoption Practice*, Vol. II, Michael Schapiro (ed.), Child Welfare League of America, New York, 1956, pp. 21–33.

the certainty of the termination, or when the medical findings raise sufficiently serious doubt to require further observation of the child. The child begins to have visual identification with the specific mother figure sometime between the ages of three and six months.[2] Therefore, being moved from one mother to another after this period can be traumatic for the child, and is more difficult than transfer at an earlier age.

Although sharing common problems, unmarried mothers show marked variation in relationship with the baby, thus affecting timing of decision to terminate parental rights and the age at which the child is free for adoption. Three groups of unmarried mothers can be identified:

1. The unmarried mother who seeks help with her decision months before giving birth, and for whom the realities against mothering are both psychological and concrete.

2. The unmarried mother who is uncertain about her decision, and needs time to test out her realities through experiencing foster home care for the baby.

3. The unmarried mother who has had no help at the time of her beginning motherhood, and who comes to the agency after her efforts at mothering have broken down, either by neglect or by self-initiated decision to relinquish her child.

In this paper I shall examine the services offered to the unmarried mother whose relationship to her child indicates she may reach a valid decision for herself when the child is less than three months of age, perhaps only a few days old. Although caseworkers have now generally accepted the fact that every effort should be made to place a child as early as possible, and at the latest within three months of birth, the unmarried mother who has decided to follow this plan meets with varied services in agencies. Rather than undertake a detailed examination of casework methods as they develop within the service structure, I shall discuss such services in terms of broad principles.

In the maternity home the impact of these services on the girls in residence is inescapable. Daily they bring to our caseworkers their feelings of despair, hostility, desperation and loneliness, suspi-

[2] Arnold Gesell, M.D., *The First Five Years of Life*, Harper and Brothers, New York, 1940, pp. 76–77.

cion toward themselves as well as others. Often their one spark of hope is the opportunity to gain confidence in other people, which up to now has been lacking. They need reassurance that their needs are considered and may be fulfilled. Every individual needs to control at least a part of his destiny, and seldom is the capacity for doing so completely lacking. The fact that the unmarried mother has asked the agency for help in planning is indicative that she cannot carry her problem alone, and needs skilled and understanding help in discovering the most satisfactory solution for herself and for the child.

In the initial application, we often find the girl is ready to make the decision that she cannot be a satisfactory parent to her child; for this reason she is seeking protection from the embarrassment the pregnancy would create for her and for her family in the community. Her wish is to place the baby as quickly as possible, and she is seeking the means to act upon this wish. Internal regrets do not interfere with a girl's functioning, if we are sensitive to what she is telling us about her capacity and readiness—or more often her unreadiness—for parenthood.

Building a Good Relationship

Not only is it important that the unmarried mother reach the right decision, but also that she reach it in a way that leaves her convinced she has chosen wisely. Her decision may take time, although no good comes from prolonging indefinitely the period of indecision. If she has sought help for herself several months before the birth of the child, a caseworker can help her examine her situation and reach a valid decision at an early date. The caseworker's estimate of the validity of the decision rests upon a sound evaluation of the stability of the girl's personality, her attitude toward the baby, her relationship with her own family and with the father of the baby. Since one of the most prevalent symptoms of some neuroses is the inability to make, and to act upon, conscious decisions based on reality situations, the agency has the responsibility to be alert to these symptoms and, if indicated, to secure a psychiatric or psychological diagnosis to support the personality evaluation. As the caseworker attempts to help the unmarried mother she must keep constantly in focus a dual reality: the psychological structure

of the mother's own personality and the demands of the outside world.[3]

Let us consider Ann, a 15-year-old youngster of superior intelligence whose family was highly educated and cultured. Her father had been hospitalized for twelve years with a mental disorder; her mother had divorced him nine years previously and after two years had remarried. Ann denied any remembrance of her father and was antagonistic toward both her stepfather and her mother who came to our agency as soon as they knew Ann was three months pregnant. The first interview was with her mother and stepfather, and the second, five days later, with Ann alone. Although she was opposed to residential care and to adoption for the baby, which were offered by her family as the only solution, she was passively submissive. She had been "going steady" with Jim, aged 16, for a long time, was desperately in love, and wanted to marry him. When the pregnancy was discovered, neither family could see "the children" as ready for marriage. Jim accepted without apparent question his parents' decision to terminate the relationship and he was sent to school in a distant state. Ann was angry and hurt, as well as heartbroken. Arrangements were made for her to continue her school work by correspondence, and for her to enter a private boarding school as soon as she was physically able after the baby's birth.

Her adjustment was precarious when she was admitted to residence a month later. She refused at first to do her school work, cried almost continually for over two weeks, and would not respond when spoken to. Nevertheless the caseworker saw her regularly and tried to convey that she cared about Ann and was there to help her. The interviews were scheduled at a regular time; sometimes Ann just came and sat. The relationship was not an easy one to establish, but gradually, over a period of five and a half months, a strong, sustaining relationship was developed. A psychiatric evaluation indicated a healthy personality, suggesting that Ann's passivity made her prone to respond to excessive overtures. Conflict with her mother and a desire to be rescued from her were evident. Ann's willingness to have sexual relations with Jim represented a need to compensate for the abrupt separation from her father. Through

[3] Ner Littner, M.D., *op. cit.*

her pregnancy she thus was able to fulfil all her needs simultaneously: she rebelled against her mother by focusing her passive dependency upon a man who would rescue and take care of her; she fulfilled her sexual needs and placed the male in the role of villain (primarily Jim's father); she established a relationship with a male figure, but did this in such a manner that once again she suffered a premature and forceful separation from him as she had experienced with her father. With the support of the caseworker, Ann's mother was able to talk with her daughter about the bottled-up feeling between them and, later, about the father's mental illness. She suggested that Ann might want to send her father a Christmas card. Ann's response had been: Should she put on the card, "Merry Christmas from someone who's locked up too"? Then she had giggled.

Following this coming together in feeling between the mother and daughter, Ann became freer in expressing her thoughts. In the beginning she could not consider giving up her baby for adoption, but her family insisted this was necessary. Our caseworker did not hold adoption as the only solution, but suggested to Ann that they work together on planning what could be done, recognizing that keeping the child would be something for Ann to consider with Jim. It was three and a half months later, when she had begun to feel closer to her mother, before she could risk writing to Jim. When he did not respond, Ann accepted the fact with some anger, but thought she had now better find out what an adoption agency could do for her. She wanted to consider placement of her child through an agency where she could be assured of adoption placement directly from the hospital. Since she could not mother the baby herself, her pain would be lessened if he could go to his permanent mother as soon after birth as possible.

Our caseworker supported the reality of Ann's need. Decisively Ann moved to apply to an adoption agency that could offer these possibilities, defining her own needs in relation to the placement of her baby. She was able to discuss the mental illness of her father and to inquire whether knowledge of this would affect the direct placement of her baby. The medical diagnosis of the father's illness was shared and evaluated. She was told that if she had a normal birth, and if the pediatrician cleared the baby medically, there was

no question but that the baby could be placed immediately with adopting parents. Ann was delighted that she had assumed this responsibility and, after the birth of the baby, she sustained with marked resolution her decision to separate from him when he was ten days old. She made effective arrangements for the next phase of her own life—entering boarding school.

Six weeks after delivery, she told her caseworker that she did wonder at times about the baby, but she had received a letter from Miss B, the adoption worker, telling her that Billy was all settled with his adoptive family; how much he weighed, and how he had grown; that the adoptive parents were delighted with him. Ann had been touched by the letter and had felt more at peace knowing that he was happy. She was proud that the grades she had received so far in school were better than her former ones. Life was looking up and she hoped that she would meet a boy sometime in the future who was not as "stuck in his family" as Jim.

The decision made by the unmarried mother usually must be related to external factors. The caseworker with whom she can develop a trusted relationship is the anchor. The girl cannot decide about adoption solely on the basis of her feeling for the child, nor can we assume that love or hatred of a child leads inevitably to keeping him or giving him up. The mother is torn between rejection of her child, who is tangible evidence of her violation of the mores of her culture, and her need to retain him as her own creation. Usually her decision comes from a consideration of the future goals she sets for herself, rather than consideration of her child.[4] If she is to give up her child with confidence to an unknown family, she must have experienced compassion, trust, and concern for herself as an individual. It is the strength of the relationship that is built up throughout the pregnancy which enables the caseworker to be effective after the delivery in helping the unmarried mother with her emotional difficulties.[5] It is the lack of such a relationship and the resultant rebuilding of the usual defenses against being helped that make it extremely difficult for the unmarried mother to arrive at a sound decision.

[4] Julia Ann Bishop, "Adoption Decision and the Unmarried Mother," *Adoption Practice,* Child Welfare League of America, New York, 1941, pp. 9–14.

[5] Leontine R. Young, *Out of Wedlock,* McGraw-Hill Book Company, New York, 1954.

Relinquishing the Baby for Adoption

In many communities it is not possible for an unmarried mother to have a consistent relationship with a caseworker. It is not unusual to find that a mother has had to deal with a family agency, a maternity home, an adoption agency, a hospital social service, a court, and a department of public welfare, all at the same time or about the same time. It is not uncommon either to find that within one agency a mother is further divided up. She must first see an intake worker and then be transferred to another worker. The resulting confusion and complexity are a major stumbling block in providing a consistent, helping relationship at so crucial a time. To the unmarried mother time itself is an important factor. A mother may apply to a placement agency for help in planning for her child, see an intake worker, and then be told that she will hear from the next worker in two or three weeks. Time passes, promises are not kept, and not infrequently the girl has not met the next worker before delivery. One girl may say, "I wonder if X agency is really interested in me?" Or another may say, "Have they forgotten me?" Another, "Are they only interested in getting my baby?"

In our agency giving service is contingent on two firm policies: that the mother work with our caseworker and, if she is considering adoption, that she use an approved adoption agency. We will not support an independent placement. Many of the girls and their families have had offers of independent adoption, and lean toward this because it offers ready acceptance for the baby and early freedom from the problem the child presents. Therefore, in making the rigid policy on which placement is carried out, we can only feel right about insisting that approved agencies be used if we know their services are flexible and are geared to the mothers' needs.

Our agency does not require that a mother see her baby, hold her baby, feed her baby, or that she physically hand over the baby to the placement agency. Many different theories are advanced about the meaning to the mother of seeing or holding the baby, paying for his care, and physically handing him over to the placement agency. We believe these practices should be considered on an individual basis as they relate to the particular mother's need. Some mothers separate psychologically from their babies at birth;

others do not. I would not dispute the fact that the physical connection with the mother, the being held and being given the breast, can be a healing process and a developing experience for the baby who has so recently left the organic connection with the mother. Nor would I dispute that some mothers cannot take responsibility for separation from the baby or his placement with an agency unless they have acted it out. People handle their separation in different ways, and it is up to us as skilled and knowledgeable caseworkers to recognize what each client is saying, feeling, and needing. When rigid policies are maintained, and are forced upon the mother by an outside will, it is done at great cost to both the mother and the baby. Still greater skill is required of the caseworker to help the mother to feel, to know, and to act upon her own needs.

Sometimes a mother in our agency has chosen to take care of her baby, and the experience has had deep value for her in giving to the child from the fulness of her desire to be a mother, even briefly, before yielding him for adoption.

Ginny spoke of the baby proudly, lovingly, as a new life beginning. She chose to take care of her baby in the hospital, so that he could be with her constantly and she could have exclusive care. The baby was in her arms during my visit. She was enjoying every minute of the baby's care, and making the most of the five days, knowing she would have to place him afterward. There was no other choice, but she was putting all her heart into caring for the baby during these five days. Proudly she showed clothing her mother had bought, scoffed at admiring comments. The clothing meant a lot more to her than just being "nice," since her mother bought it by babysitting for six days, putting up with a "mean woman." I recognized that this meant a lot to Ginny. She was touched that her mother would do this—accepting it as acknowledgment of the baby. Yet the mother left all the planning to Ginny. There had been no change in her plans—she had to place the baby for adoption and get a job. All she could think about now was imagining herself and Mom—just sitting at home, eating a steak sandwich. . . . On the day of placement I found Ginny a little annoyed at the baby. "Here I have fed him and wanted to play with him because it is the last time we will be together, but he does not seem to know this or to care. He has gone to sleep."

Some mothers cannot bear to give more than birth itself:

Miss E was thankful that the baby had been born, since this meant she would have no problem in returning to college in March. I wondered if she still found it hard to talk about the baby. Her eyes filled with tears. Although she had not seen her, the doctor assured her that the baby was quite healthy. With

much feeling, she hoped I did not think her "hard hearted." She just could not feel any love for the baby, although she did have some interest in her. During the few months at college she had a taste of something different for herself, and didn't feel ready or able to give this up. I agreed with Miss E that she was right to act on her own feelings.

One mother discusses seeing her baby:

There were signs that Miss H had been thinking more about the baby. In fact, she told me that she had thought more about her in the last two days than ever before. Maybe this was because she had had a dream, a very vivid one, about her taking the baby home to her mother. Since then she had been wondering if the baby looked like the one she saw in her dream. A little timidly she asked what color hair he had, and when I told her it was light brown, she said, "That is just like the baby's father." Had she thought any more about seeing the baby? Miss H thought it was best not to see him—that would only make it much harder. I accepted this but suggested that she might decide later to see the baby, as she might find that she was more worried in trying to imagine just what he looked like. Miss H thought she might decide differently but right now it would be best not to see him. She spoke of the father of the baby, his desertion of her as soon as he knew that the baby was on the way, and her feeling that she never wanted to see him again. "It hurt me more the way he done, than it did about the baby." I guessed these two things were so close together that perhaps the baby could not mean anything good to her. Miss H said the baby meant only trouble to her.

Terminating the Parent's Legal Rights

Agencies working with unmarried mothers vary widely in their timing for acceptance of legal termination of parental rights. It is generally agreed that termination should be timed in accordance with the mother's need and emotional readiness to give up her child. The agency's decision to accept legal termination of parental rights should not depend on whether, or when, the child is placed for adoption; the refusal to accept this termination when the mother is ready often results in complications. The mother may leave the agency and find someone who is willing to accept this decision and her child. Thus, there are hazards for the mother, and the baby loses the protection and judgment a skilled adoption service can provide in the selection of his lifetime parents. Frequently the refusal on the part of the agency to accept the mother's necessity to terminate plays into her ambivalence, keeping her suspended in an in-between world. She may be unable to give up her child, yet unable to provide him with the mothering he needs. In many

instances a mother can accept early legal termination of parental rights for her child by anticipating her early freedom from the problem that the child represents. She will be able to establish herself more quickly and surely in the community. In some instances, early separation from the baby requires a great deal of fortitude on the part of the mother. She feels a close relationship to what she herself has created but gives thoughtful consideration to the advantages for the child she loves in being settled quickly and permanently in a home.

Service for Miss L began in the sixth month of her pregnancy. She had worked as a graduate army nurse, and, at the age of 35, she had had considerable life experience. At the time of her initial request for help, she said her relationship with the father of the baby was over. He had no interest in marriage, and they both had recognized the casualness of their relationship. A lawyer was negotiating with her and with a prospective adoptive couple to take the baby. The caseworker accepted Miss L's need for early placement of the baby, but could not support her in independent arrangements. Miss L struggled with this restriction, but decided to accept the service because she needed residential care and protection. She could not ask her family's help and had no money saved for an emergency. On the day of admission she signed an agreement stating that if placement for her baby was needed, it would be done with the knowledge of our agency's caseworker and through an approved child-placing agency.

During the three months in our residence Miss L was very much alone. She had one friend who visited. Since the lawyer knew her name and where she was, he did not give up the quest. He met her in the park, and he and the hopeful adoptive parents sent expensive gifts. She needed and liked the attention and kept the lawyer dangling. She also accepted referral to a child placement agency, one that could offer immediate termination of parental rights. The worker from this co-operating agency saw her consistently, never deviated in her promise of an appointment, and there was close collaboration between our worker and the placement worker. Following birth, Miss L sustained her decision to place her baby through the agency, and signed the legal document for termination of parental rights when the child was ten days old.

In the final interview eight weeks later, she expressed deep gratitude for everything our service had done to help her with her problem.

She said, in part:

> You will never know the wonderful feeling I have and how I thank you for introducing me to Miss N. She never let me down. There was a kindness and a deep understanding help which I got nowhere else. What meant most to me was her continuous help through it all and her willingness to accept that I was not all bad because I wanted my baby placed immediately for adoption. It was not that I did not care for my little Stephanie, but rather I had to decide to give her a chance for happiness in a family, because I was alone. I was sad, and I still have a feeling of sadness, but I know she will be happy by going to a permanent family so soon after birth. In thinking of this, with time and life going on for me, I know that I did the only thing possible for both of us.

This final statement helps to explain why staff members at the Florence Crittenton Home of Philadelphia have conviction about helping the unmarried mother through the structure of an agency, with the core of the service centered in the consistent casework relationship, with the timing geared to the mother's need for these services. Infants, we believe, can be placed for adoption under four weeks of age, if the agency provides skilled casework for the natural mother, maintains a high standard of obstetrical and pediatric care, and believes that some adoptive couples have the capacity to accept the normal risks of a child's development.

THE SELECTION OF ADOPTIVE PARENTS AT INTAKE

Donald Brieland, Ph.D.

SELECTION OF ADOPTIVE PARENTS should be of interest to both social work and social science researchers. It provides the ideal situation in social work practice for the development and application of a model of effective family functioning and child rearing based on concepts of positive mental health. The major concern in adoptive placements is not with psychopathology, rehabilitation, or financial need, but with contriving the best possible parent-child relationships by selecting parents from a rather large group of applicants. This paper will be confined to selection of parents for infants rather than for older children, for whom there is a shortage of applicants. Selection requires not only the development of a model, but also predictions about the capacity for parenthood—a complicating factor in serving childless couples. The social agency has the responsibility of selecting the best qualified couples and eliminating from consideration those who are not so well qualified. The first decision to continue or discontinue interviewing a couple usually is made after one intake interview in relation to their general suitability as parents, rather than on their suitability for a particular infant.

In the research project jointly sponsored by the Elizabeth McCormick Memorial Fund of Chicago and the Child Welfare League of America, 184 workers from 27 agencies in various parts of the United States evaluated the same five tape-recorded intake interviews with adoptive applicants. They agreed with each other significantly better than chance on their decisions to continue or discontinue

contact with the applicants, but the differences in their judgments were often sharp.

Methodological Problems

In some agencies, agreement did not exceed chance. Our concern here is not with the findings, which are available in the monograph published by the Child Welfare League[1] but with methodology, additional findings, and implications for future research. I shall deal with methodological problems first, since these are of concern to the practitioner in interpreting the results as well as to the researcher.

Six topics will be treated briefly:

1. *Lack of visual cues:* When tape recordings are used, the worker-judge is denied the help of visual cues obtained from seeing the couple who apply. Visual cues would probably alter some of the decisions. Since they add variables, they might well serve to reduce agreement. Video tape recording, closed-circuit television, or filming would be desirable. Closed-circuit TV, viewed live from another room, would provide no permanent record of the interview unless it were also tape recorded, which could be done. Video tape recording of high quality would be preferable. With adequate technical arrangements, client co-operation would present no problems.

2. *Differences in applicants:* The couples served by one agency may differ substantially from those served by another. Differences that worker-judges considered important included urban versus rural residence, socioeconomic status, and ethnic identifications. Whether such differences distort judgment, one cannot say. Ideally, for testing judgments, agencies should use cases that are similar to those they themselves serve, if not actually those from their own intake. Research limited to an agency's own cases, however, would eliminate interagency comparisons, which are often most enlightening.

3. *Role-playing:* Having to react to another person's interview for purposes of research may constitute an artificial situation and become an unreal role-playing task. Would the decisions differ if the worker were actually responsible for the case? There can be no definite answer to this question; it is possible there would be a

[1] Donald Brieland, *An Experimental Study of the Selection of Adoptive Parents at Intake,* Child Welfare League of America, New York, 1959.

greater feeling of responsibility among workers if cases came from their own agency.

4. *Decisions on one interview:* Should there be more than one interview to evaluate couples who are tentatively accepted following the intake interview? Tentative decisions could be tested by securing additional evidence. In the research project, time scheduling with 184 workers in 27 agencies did not permit such a procedure. Another question may also be raised: In at least some cases, should the agency be able to confirm, by more interviews, the reasons for its tentative decision to reject? In practice, rejected clients typically are permitted to re-apply at a later date. Thus, the door is left at least partially open for future contact. Would additional evidence from a second interview be useful enough to outweigh the disadvantages of raising the hopes of couples who would still have to be rejected? It was the firm conviction of several participants in the study that valid decisions could not be made on the basis of one interview, even though, as we have seen, this has become the typical occasion for the elimination of a number of applicants; to the applicant the initial interview is the first hurdle to be passed.

5. *Need to reflect:* The time pressure under which interviews were heard made judgments difficult because there was no chance for reflection before a decision was made. Some worker-judges said that, in their own practice, dictating the record preceded and influenced their own decision making. A replication study with a smaller sample should make it possible to overcome the time pressure. Implied here is an interesting hypothesis that time to reflect increases the validity or reliability of decisions. We shall return to this hypothesis later.

6. *Should workers agree?* Should workers be expected to agree with each other on decisions concerning adoptive applicants? Two principles are involved here. One concerns the application of theory. Should it not be possible to distinguish life experiences and attitudes associated with parental capacity from those associated with incapacity? The need for a common frame of reference and perhaps for common criteria is suggested. Most workers obviously operate according to certain principles whether or not they have articulated them. A body of practice theory can be brought to bear on this task. The second concern is equitable treatment of clients. Adoption is

a desirable social goal both for the agency and for the applicant, and couples are encouraged in their desire to adopt. If parents are to be evaluated, those who are better fitted to be parents should receive children and those who are not so well fitted should not. When one worker's decisions differ so strikingly from those of his colleagues as to suggest different value systems, acceptance or rejection may depend too much on the values of the particular worker assigned to interview applicants. The report of the project emphasized that agreement among workers (that is, reliability) does not imply the best decisions (that is, validity). But unreliability automatically implies some degree of invalidity. We can all agree and all be wrong, but we cannot disagree among ourselves and all be right.

Interview Procedures

Two of the problems in the study are worthy of full discussion because of their implications for practice. One deals with differences in interviewing among the worker-judges. The interviewer in our study followed a rather similar procedure in talking with each of the five couples. Each of the five interviews dealt with twelve general areas in about one and one-half hours each:

1. The couple's interest in a child, including sex and age, coloring, and background.
2. First-hand contact with other couples that have adopted.
3. General experience with children (including own children if not childless).
4. Telling the child of adoption and giving the child information about his identity, including any reading the couple has done on the subject.
5. Attempts at having own children, including sterility studies.
6. Development of interest in adoption on part of couple, including which partner's interest is stronger.
7. General sketch of family life experiences, including verbal description of adoptive applicants and attitudes toward parents and siblings.
8. Educational history, including attitude toward school.
9. Marital interaction.
10. Employment history and attitudes.
11. Social participation in present neighborhood.
12. Religious participation in present neighborhood.

In order to cover the topics, he asked many direct questions and sometimes, if responses were long, he found it necessary to interrupt the couple and move on to another topic. Some of the worker-

judges said that they followed a similar procedure in their own intake interviews. Others were accustomed to giving clients much more freedom and letting them determine to a greater degree the content of the interview. These workers had more difficulty in evaluating the five project interviews. In short, some workers felt they got too little specific information from the intake interview; others felt that they got too few responses that revealed deeper motivations. The latter would have preferred to have the couple reveal their own feelings through a freer interview. We learned that, to many workers, the best interview is their own interview! This impression was not unexpected. Most workers used some combination of the two approaches contrasted above. It did not seem worth while to ask workers to classify their own interviewing method, since such a classification might not represent what they actually did.

Two questions are evident: Should the first interview be mainly centered on childhood experiences of the applicants, experiences with children in recent years, and attitudes toward child rearing or similar topics? Should the same general ground be covered by all workers with each couple or should the determination of subjects discussed be left much more in the hands of the applicant? It can be hypothesized that the less workers elicit evidence about the same topics, the less they can reach comparable decisions. Any method for evaluating adoptive applicants, one might argue, should be focused primarily on the applicants' interest in children since that is why they come to the agency. Also, an unfavorable decision may be better accepted by the couple if the interview deals mainly with the subject of children rather than directly with adult personality characteristics; the latter focus gives the interview some of the elements of a projective test.

Problems in Evaluating Data

Our findings suggest that the worker frequently makes a global evaluation from the early portion of the interview and fits later evidence into that impression. Sometimes, of course, he changes his mind on the basis of new information. The simple matter of deciding whether a couple is liked or disliked has many hazards. In our study, impressions of a couple formed by workers from the

same agencies were often strong enough to lead to opposite decisions. Reasons for the judgments made were revealed both in the written summaries and in discussions that followed completion of the project in each agency. One example: The dominance of a male applicant was an over-riding negative characteristic to one worker-judge because it reminded her of someone in a similar occupation whom she disliked. To her this suggested *coldness.* To a colleague who had heard the interview at the same time, dominance was favorably regarded. Reference was made to the similarity of the man's attitude to that of one of her own relatives. The applicant was described as *warm.* We cannot and should not try to eliminate all these elements from judgment, but it is hard to relate such influences on judgment to the issue of parental capacity. Can a common and more uniform focus in the worker's own interviewing serve as a corrective for some of the elements of countertransference that otherwise may make interviewing only a time-consuming equivalent of flipping a coin?

Unless workers are looking for the same things and covering the same general topics, it is hard to expect reliability. This conclusion strongly suggests that training include experimental use of sample interviews incorporating those variables that an agency finds important and illustrating techniques that are considered most effective.

Another problem in the selection process is the amount of data from the interviews that the worker must process. He cannot possibly react to all the potential evidence that he hears and sort it out by means of his own value system. Unless he has developed a way of identifying and retaining relevant material, his judgments will tend to be unreliable. It may seem that it was easier to process data in the research project than in actual practice because the worker did not have to conduct the interview; he had only to listen to it. Also, he could refer to the written transcript of the interview and take notes if he wished. However, the transcript of each interview was longer than an entire case record in adoption or foster care. The length is typical of that of first interviews in most agencies. When there is so much material, a system for identifying significant portions of the interview should make data processing easier and assure that important evidence is not overlooked.

I should like to come back to the workers' need for time to reflect.

The passage of time may make decision-making easier because it leads to selective forgetting, so that there are fewer data to contend with. If the interviewer has not taken detailed notes, there is danger that potentially important evidence may be forgotten and the decisions made in terms of stereotypes.

Although we gave the same amount of information to all the worker-judges, we studied a second group of judgments of 79 workers from comparable agencies who had only the data from the registration blanks of the five couples interviewed in the first study. Topics included: age, length of marriage, physical description, education, employment, income, housing, debts, life insurance, own children, reason for sterility, and religion. Detailed results of this study are now being prepared for publication. Briefly, it was found that on four of the five couples, the judges showed less agreement than did those who had heard the taped interviews. On the fifth, the agreement was significantly higher but the decision was in the reverse direction. We have not been able to explain the difference on the fifth case. Workers in the tape study most often cited the general immaturity of the couple as the reason for rejection. Obviously, this characteristic did not come through on the registration blank and the couple was accepted by 90 per cent of the judges in the second study.

Use of Research Findings

From Wolins' research on selecting foster parents, we thought that agreement might be higher when only data from the registration blank were used, because each worker-judge would have evidence on only a manageable number of variables. Some of the agencies participating reported that workers felt unwilling to make decisions on the basis of so few facts. This expression of feeling came as no surprise in view of the vast amount of material with which they are usually faced.

The Washington Children's Home Society in Seattle showed 91 per cent agreement in the tape study. This was the only agency in the study that had conducted a long-term staff development project on the characteristics of good adoptive applicants. It seems likely that the staff development experience one day a month had given the workers in this agency a common frame of reference so that

they processed data with more nearly similar results than the workers in any other agency.

It is questionable that there is need for another study dealing with the level of agreement of workers unless special attention is paid to the characteristics of effective adoptive parenthood that can be elicited and evaluated from a pre-adoption interview. Each of several agencies might develop its own conceptual framework and specific criteria. These could be made more specific and detailed than those now in use, if much more attention were given to theory-building. Agencies then might pool their efforts and work out a composite model which would be applied in their interviews. If the effects of worker training were to be measured, a before-and-after series of interviews could be judged. Agreement could be studied by video-taping interviews and evaluating them, using the method of the McCormick Fund project. Comparisons could also be made with judgments from agencies in which there had been no special training program.

There are, it appears, two central questions. Can such a schema be worked out, and do caseworkers agree when they use it?

Agency-developed schemata should aid workers in their judgment task, but it would be more useful to have a project that involved both agencies and research personnel from other disciplines. As Hunt,[2] among others, has pointed out, we know very little about the personality variables that affect child rearing. Although the work of several investigators[3] has provided helpful measuring scales and guides, much more work is needed before a model for selecting adoptive parents can be developed. Not only are the major variables of personality that may affect parenting unclear, but the approach to the problem must be congruent with the demands of agency practice. We do not want to substitute a scale for the caseworker. A major part of the task may be that of making explicit

[2] J. McVicker Hunt, "On the Judgment of Social Workers as a Source of Information in Social Work Research," *Use of Judgments as Data in Social Work Research*, National Association of Social Workers, New York, 1959, pp. 38–54.

[3] A. L. Baldwin, J. Kalhorn, and F. H. Breese, "The Appraisal of Parent Behavior," *Psychological Monographs*, Vol. LXIII, No. 4 (1949).

R. R. Sears, Eleanor E. Maccoby, and H. Levin, *Patterns of Child-rearing*, Row, Peterson & Co., Evanston, 1957.

Earl S. Schaefer and Richard Q. Bell, "Development of a Parental Attitude Research Instrument," *Child Development*, Vol. XXIX, No. 3 (1958), pp. 339–61.

elements that are now vague or implied. For example, it would be generally agreed that *warmth* is an important element in parent-child relationships. Yet studies of therapy show that judges disagree considerably in their observations of clients as being warm or cold.[4] The illustration of the dominant applicant earlier in this paper is just one example of the difficulty in using the concept of "warmth" until it is specified and operationally defined.

Would a substantial research program on this subject be over-ambitious? Would it concern only a limited problem and a small number of people? The development and application of a model to evaluate adoptive applicants would be useful in studies of parent-child relationships in foster family and natural family situations. The model would also provide a tool for adequate follow-up studies in adoption—much talked about but not yet carried out, partly because existing case records do not include enough specific data on the basis for selection and non-selection of couples. The issue, then, is much broader than worker reliability. Subsequent research should not only aid practice but also make a contribution to related fields concerned with the optimum development of the child.

[4] J. McVicker Hunt, *op. cit.*

A PROJECT IN GROUP EDUCATION WITH PARENTS OF RETARDED CHILDREN

Salvatore Ambrosino, Ed.D.

THE LAST DECADE has seen a phenomenal growth in efforts to help parents of retarded children. This decade has also brought an increasing interest in the use of group methods of learning for many purposes. It is not surprising, therefore, to find that many kinds of group approaches are currently being used in programs for parents of retarded children. These approaches vary in goals, some having an educational focus and others a treatment focus. This paper will describe a group education project for parents of retarded children and the particular group method used. It will also point to the potential value of such programs as a means for helping such parents deal with their special problems. The project was co-sponsored by the Child Study Association of America and the New York City Chapter of the Association for the Help of Retarded Children.[1] For several years the AHRC has offered educational programs for parents, usually consisting of a series of six meetings. Some programs have been in the form of lectures covering significant aspects of mental retardation, followed by a question period; others have been discussion meetings. In planning the joint project, the sponsoring agencies were motivated by the following conditions and objectives:

[1] For the purposes of brevity, the two sponsoring groups will be referred to as CSAA and AHRC.

1. The CSAA, in its work with parents of normal children,[2] has developed an effective philosophy and method of parent group education. In recent years, it has also participated in a number of experimental projects in which this method has been applied to work with parents of children who have a particular physical handicap. It has been found that this work has been of the utmost importance in helping these parents carry their difficult and potentially overwhelming tasks in ways that will contribute to the best possible development of the handicapped child and to the mental health of the family as a whole.[3] The CSAA, therefore, welcomed the opportunity to extend its experience by working with a group of parents whose children are mentally retarded.

2. The AHRC, in turn, was eager to experiment with a new group discussion program that would provide ample opportunity for focusing on the needs and concerns of the parents it serves.

The discussion group to be described was offered in the spring of 1959 by the AHRC as one of several different group programs for parents of retarded children given at the Chapter's headquarters. The CSAA gave consultation regarding recruitment of members, interpretation of the program in printed announcements, and other aspects of organization. A member of its staff also served as group leader.[4] Announcements of the project were sent to the local membership of AHRC and the project was given publicity in the community. As a result, twenty parents, including four couples, registered for the group.

The group was limited to parents of preschool children. This procedure is the general policy of the CSAA; it is based on the fact that parents identify areas of common concern more easily if the

[2] *Parent Group Education and Leadership Training: Three Reports,* Child Study Association of America, New York, 1954; Aline B. Auerbach, "Trends in Parent Education," Reference Papers on Children and Youth, White House Conference on Children and Youth, 1960; Gertrude Goller, "The Place of Psychodynamic Orientation for Professional Leaders in Parent Group Education," *Journal of Psychiatric Social Work,* Vol. XXIV, No. 4 (1955), pp. 231–237; Gertrude Goller, "Use of the Small Discussion Group in Parent Education," *Social Work,* Vol. II, No. 2 (1957), pp. 47–53.

[3] Aline B. Auerbach, "What Can Parents Gain from Group Experience?" *Helping Parents of Handicapped Children—Group Approaches,* Children's Medical Center, Boston, and Child Study Association of America, New York, 1960.

[4] The author of this paper served as leader of the group and Florence Shaffer, caseworker on the staff of AHRC, acted as resource person.

groups are set up for parents whose children fall within similar age ranges.

Six registrants did not attend any of the meetings and five members dropped out by the third meeting. The drop-out rate was slightly higher than the average for groups of parents of normal children. It may be attributed to the following special difficulties: inadequate baby-sitting arrangements, the parents' reluctance to leave their children, low morale of the parents, and, possibly, disappointment that the program offered no easy solutions to their problems.

The group met weekly for eight sessions. The attendance ranged from five to eleven parents, averaging eight to nine members at each session. A basic group maintained regular attendance. The CSAA usually finds it advantageous to close a parent group to new members after the second meeting, especially if the group is large enough (approximately twelve to fifteen members) to offer the range of experience necessary for fruitful discussion. However, because attendance in this group dropped markedly, it was decided to admit new members in the third and fourth sessions. It was felt that the advantages of having a larger group would offset the disadvantage of prolonging the time it would take for the members to learn to work together as a group.

In preparation for conducting the group, I reviewed materials on mental retardation and observed retarded children in a school setting. I had previously gained some familiarity with the problems of parents of handicapped children in earlier professional experiences. When the members needed factual information, such as specific data on mental retardation or on community resources for retarded children, these questions were referred to the resource person.

Subjects of Parental Concern

The parents were encouraged to bring up and pursue whatever subjects were of paramount interest to them. They understood there would be no fixed curriculum. In the opening session, the leader asked the group members what they wished to discuss, and a tentative agenda was drawn up. The original list of topics

was referred to from time to time by the members or the leader, and it was used flexibly, as a reminder of initial interests rather than as a fixed outline. Topics for discussion were selected by the members from meeting to meeting. Therefore, at each session the members and the leader faced the task of selecting areas for discussion that were of both immediate and general concern.

The leader's role, as defined to the group, was to help them focus discussion on important common problems as well as to guide their discussion so that the basic aspects of the various questions would be explored; and, further, to offer information when it was appropriate to do so. The leader also explained that the goal of the program was to help the members share their experiences, ideas, and feelings about their children and about ways of meeting family needs. Moreover, it was explained that such an exchange of experience was designed to broaden the base of their thinking and help them to arrive at their own solutions.

The group discussed a broad range of problems, such as how to determine what can be expected of retarded children and how to help them make the best use of their abilities; when punishment helps or hinders a child in growing up; toilet training; eating habits; the burdensome feelings of despair and guilt experienced by parents; relationships of the mentally retarded child to normal children in the family and in the community; and resources and programs in the community that might be of help. Some of these areas were discussed in detail while others were explored more briefly.

The most basic problem parents presented was their uncertainty as to what should be expected of retarded children in the different developmental phases of growth. One husband and wife disagreed vehemently on the matter of discipline. Should their 3-year-old child be disciplined as a normal 3-year-old or as an 18-month- or 2-year-old child? One mother commented that her 5-year-old daughter, anticipating parental disapproval, often burst into tears when asked to dress herself. Another parent reported that she had always fed her daughter, who was now 3½, but the mother recently discovered the girl eating by herself one day when she was being cared for by her grandmother. When the child saw the mother enter the room, she handed her mother the spoon.

Illustrations of extremes of overprotection, as well as excessive

pressure on the children, led to the recurring question: How can parents determine their child's readiness for new tasks? The members of the group drew many parallels between their special child-rearing situations and those of rearing normal children. They were able to see that the principles for determining readiness for further development were comparable. At the same time, they realized that they could not anticipate regular growth steps for the retarded child as they could for normal children. Many members recognized the need for testing a child's readiness to learn and spoke of the difference between putting pressure on a child to perform and encouraging him to learn. Several parents reported surprisingly good results when they approached their children with confidence that their requests would be understood and successfully carried out. A mother of 6-year-old twins, who are cerebral palsied as well as retarded, spoke of her exhaustion from carrying the boys upstairs. One day, in desperation, she placed their hands on the rail and, in a stern voice, ordered them to climb. To her utter amazement the boys struggled to the top of the stairs without her help. A member of the group commented that the boys were ready for this task, but another participant, pointing animatedly to the twins' mother, said, "No, *she* is the one who was ready." Stories were told, too, of how fatigue and despair drove parents to do too much for their children because this was easier than going through the tedious process of teaching them to do things for themselves.

The everyday problems of discipline were discussed at great length in this group, as they are in all parent groups. Yet here the comments had special overtones. Many parents felt guilty about punishing the retarded child because, frequently, they were unsure about whether the child really understood either their requests or the reasons for the punishment. In the discussions about discipline, the group members emphasized the importance of understanding children's needs. They struggled with the question of when to be firm in an effort to determine when holding the line with punishment is helpful and when such action is likely to provoke hostility and further misbehavior. They also spoke of trying to find ways to express their own natural annoyance and hostility in a manner that would not have a sustained impact on the security and happiness of the child. A rewarding insight was offered by one mother who

expressed the barely recognized feelings of many members. She stated that bright children can afford to be different but that retarded children have to conform; otherwise their limitations become the focus of undue attention.

The parents also talked about their relationships to their handicapped children as compared with their relationships to other children in the family. One mother insisted that she treated her retarded child exactly as she treated her other children. Her need to repeat this statement, despite the absence of any challenge from the group, may have betrayed the fact that she tended to indulge her retarded child. Most of the parents confessed that they "spoiled" the retarded child and that such special attention served to heighten the tension between siblings. Several parents expressed their wish to change their way of handling the children and avoid favoring the handicapped one. At the same time, they recognized that it was not easy to change their ways.

Helping Parents Face the Fact of Retardation

As the meetings progressed, the members increasingly felt themselves to be a part of the group and, by the fourth and fifth sessions, developed a strong spirit of joint endeavor. They were now able to discuss some of their more painful problems. Perhaps the most meaningful discussions were those that revealed the parents' deep feelings of guilt. One mother felt guilty because she had attended a prenatal clinic, when she was pregnant with her retarded child, in spite of her family's advice that she go to a private physician. Another woman reported that she felt guilty because she had gone to a private doctor instead of to a clinic. At first, each supported the other. But, finally, these two women realized the lack of logical basis for their feelings.

In general, the heavy burden of guilt carried by this group seemed to be tied to an assumption that parents somehow are always responsible for what has happened to their child. It is interesting to note that one mother, who knew that her child's condition was due to a virus she had contracted during the early months of pregnancy, said she did not feel guilty. Another parent said, with much feeling that, since the other members did not know the reasons for the

afflictions of their children, they had little choice but to blame themselves. As they talked, they saw the similarity between their reactions and the guilt feelings of persons who lose a family member through death. After this discussion, the group members appeared to understand more clearly that their guilt feelings, while understandable, had no basis in reality.

The parents were troubled, too, because they could not be sure they had done everything possible to secure treatment for their children. Heartbreaking stories of "doctor shopping," long familiar to workers in the handicapped field, were brought out by many members. The reports of these experiences highlighted their terrible dilemma: on the one hand they knew that it was foolish to go from one doctor to another and, on the other hand, they were fearful that they might overlook some resource that might be helpful. The dilemma was heightened for some parents by the fact that they had received conflicting medical reports. They expressed a deep bitterness about the lack of clarity and also about what many felt to be a lack of sympathetic understanding by physicians. Furthermore, although excellent clinic resources exist in New York City, which offer some hope for retarded children, these parents encountered difficulty in securing help because of long waiting lists.

At one of the closing meetings, the grouped talked about the difficulty of accepting the fact of having a retarded child. One mother cried uncontrollably, stating that this burden was too much for her to bear. This opened the floodgates to further expressions of despair. One member, especially sensitive to the reactions of other children to her child, talked about frequently "escaping from the playground." In desperation, she said that she was "on the run and didn't know where to run to any more." Tears came to the eyes of many of the members, partly in sympathy for the suffering of the others and partly because of their own sorrow. The stronger members, some of whom had lived longer with the problem, quickly supported the parents who were most distressed, telling of their own experiences and how they had come through them. It helped all members to realize that there are stages of shock and grief that all parents have to pass through before they can achieve any degree of acceptance of the problem. Toward the close of this discussion,

one mother said fervently, "Life isn't easy. It's tough for everyone, but it is worth while. Sometimes one has to suffer many days for that one good day, but that one good day is worth it."

The group was not satisfied, however, with this discussion of acceptance. At the next meeting, one member asked how it was actually possible to accept the fact of retardation when one knew that, as a child grew up, he would be unable to enjoy life as others do. One father reacted differently and described the happiness of his child on a picnic. Other experiences were then cited supporting the father's position that these children can enjoy life. These remarks led to a discussion of the importance of emotional well-being. The parents seemed to come to a fresh awareness of the fact that retarded children respond to them on an emotional level very much as other children do. In fact, in another discussion about institutionalization, many parents talked about the emotional satisfactions the retarded child brought to the family.

The sequences that have been presented from one discussion series give evidence of the major concerns of parents of retarded children and also suggest the value of a group educational experience as a way of helping them with their troubled feelings.

Objectives of Parent Group Education

A few comments should be made about the objectives of parent group education and about the procedures. A detailed discussion is beyond the scope of this paper, but I should like to clarify a few common misunderstandings.

Many professional workers assume that an educational program is geared only to information and takes place solely on an intellectual level. The kind of program described here, therefore, is often considered a form of therapy since its purpose is to encourage the expression of feelings and experiences of the members, as well as to have them talk about their ideas. However, since this group method makes no attempt to focus on or to resolve the individual conflicts of the members, it cannot be construed as therapy in the strict definition of the word. The members, however, may achieve therapeutic gains since the group parent-education goal is to help members increase their effectiveness as parents and gain emotional

comfort. Because the group members are given broader perspective from which to view their problems and are exposed to a wider range of emotional and behavioral responses, they have the opportunity to develop greater capacity to make rational and wise choices. The interaction of the members provides the key dynamic to the learning and the emotional change that may occur. As members contribute their own experiences and react to the experiences and attitudes of others, they are able to decide with some objectivity the position to take and what they wish to be like as parents. In this process the member may, or may not, verbally express his ideas. A chief task of the leader is to guide the discussions in such a way that they are held within the framework of what is relevant for the group as a whole, thereby involving as many members as possible.

This project suggests that the method of parent group education developed for parents of normal children is adaptable to meeting the needs of parents of retarded children. Although this was a brief and limited experience, the program appeared to have made the following positive contributions:

1. Parents experienced a sense of relief and support in sharing their mutual problems. Many of them stated that they no longer felt so alone.

2. In many cases, an overwhelming sense of guilt appeared to be somewhat eased.

3. Parents seemed to gain a better understanding of their retarded child, their relationships to him, and the special factors operating as the result of retardation.

4. Parents appeared to have a better understanding of how to gauge the child's readiness to take a forward step in development and to be more alert to the many alternative ways of helping him.

5. With the assistance of the resource person, the members became better informed about community resources and the work of the AHRC. They also developed more realistic expectations about these services and how they could use them.

It is interesting to note that the attendance in this group held up better than that of other group programs which were more structured in approach, offered simultaneously by the AHRC. It was the impression of the resource person and of another staff member

of AHRC, who came occasionally to observe the meetings, that the members of this group gained greater benefits from their experience than were gained by members of other programs.

It is important to ask if this particular group had any characteristics that distinguished it from similar groups attended by parents of normal children. This is a difficult question since parent groups vary almost as much as do individual personalities. One impression that stands out, however, is that these parents of retarded children appear to have a higher level of anxiety. In view of the fears and heavy burdens they face, such anxiety is, of course, understandable.

The adaptation of the basic group method to meet the needs of these parents posed a few special problems. The members of this group seemed to need more time to explore the deep and complicated feelings that were associated with many of their concerns. In many discussions, too, the group was unable to make use of the concepts of development that are generally applicable to normal children; for example, knowing the range of behavior to expect from normal children in adjusting to toilet training does not help appreciably if one is considering children with varying degrees of retardation. This factor led to emphasis in the discussions on how to capitalize on the child's readiness to take forward steps in development, whatever his chronological age may be.

The experience in this project suggests the following recommendations for the further use of such programs: (1) that a large enough number of parents be registered so that the average attendance at meetings may be maintained at about twelve to fifteen parents (twenty to twenty-five initially if one expects the drop-out rate will be similar to that of this group); (2) that the series be planned to run for twelve to fifteen meetings, since it usually takes from three to five meetings for the group to develop the cohesive spirit that is essential for the learning process.

In summary, this project further confirms the conviction, based on similar experimental efforts with groups of parents whose children had physical disabilities, that organized discussion groups can make a significant contribution to the welfare of families with retarded children.

ALCOHOLISM IS A FAMILY ILLNESS

Gladys M. Price

IMPROVEMENT IN ONE family member who is known to be sick is frequently countered by an outbreak of disturbance elsewhere in the family system; apparently the illness of one member has functional significance for family equilibrium. This phenomenon has been noted by Florence Kluckhohn.[1] The purpose of this paper is to illustrate the course of rehabilitation of an alcoholic and to highlight the changes in his family relationships.

Mr. K had been hospitalized at the Washingtonian Hospital, as a result of acute intoxication, four times between 1952 and 1956. This hospital is a medical and psychiatric treatment center for alcoholics which offers both in-patient and out-patient services. Three weeks after his last discharge, Mr. K made application for treatment on an out-patient basis. When he arrived, he was accompanied by his wife, making it clear that this was a joint venture. Since that time, he has not relapsed into drinking.

Mr. K, aged 37 at the time of application, was a large man, pleasant and intelligent in appearance, but with an expression of apprehension. Mrs. K, aged 39, was of medium height, stocky, also pleasant in manner, but exhibiting a slight scowl and a kind of reserve. Both were plainly and comfortably dressed.

[1] Florence Rockwood Kluckhohn, "Variations in the Basic Values of Family Systems," *Social Casework*, Vol. XXXIX, No. 2-3 (1958), pp. 63-72.

Family Background

Mr. K was one of seven children. His father still worked in a canning factory. His mother, an illiterate woman who was now deceased, had been the disciplinarian in the family. Both parents had been heavy drinkers.

After Mr. K had finished high school, he had been in the army, where he had qualified as a pharmacist's assistant. Later he had worked for an engineering firm, and for the past two years had held a federal civil service job. In 1946 he had married a girl two years his senior. Six months after the marriage, she had had a hysterectomy. The need for this surgery had come as a surprise to Mr. K.

From the beginning Mr. K spoke freely about his drinking problem. He had considered himself a compulsive, periodic drinker, "because of inner tensions," for twenty years. There had been a marked increase in the frequency of his bouts within the last two to three years. We noted that this increase coincided with his starting to work in his present job and followed by about one year the death of his mother.

The evaluating psychiatrist stated, in part, "The patient's good work record and adequate intelligence are elements in his favor. The compulsive nature of the drinking shows clearly that it satisfies some present instinctual demand. Diagnostically, I can only fit him into the category of a passive, dependent person."

Mrs. K also presented a background of deprivation. During the depression her father had had little work and her mother had been the main support of the family. Responsibilities for mothering her younger siblings had fallen to her. She told of having been called upon to beg food from neighbors and to rummage through trash cans. She was ambitious, however, and had gone to a school of design. More recently she had taken up portrait painting.

Early Attempts at Adjustment

Prior to seeking professional help, the K family had taken various steps to make an adjustment. Mrs. K had known of Mr. K's drinking when she married him but had been hopeful that, once married, he could bring it under control. We shall call this step one, or partial denial of the drinking problem.

Early in their marriage, they had lived with one of Mr. K's sisters, who was a heavy drinker, and there had been wild parties. After a year, Mr. and Mrs. K had agreed that they should move to their own place, hoping in this way to control the extent of Mr. K's drinking. Perhaps we can call this step two, or an attempt to eliminate the problem.

After they had moved they drifted further apart. They were both working and Mr. K had a second job at night. They saw little of each other and Mr. K's drinking increased. We shall call this third point the stage of disorganization.

Four years after marriage, in an attempt to reorganize their family life, and in spite of the drinking problem, they had adopted a one-year-old boy. Mrs. K stopped working, and they bought a house in the suburban community where Mr. K had been reared. However, the new home and the adopted son seemed to bring no improvement in the lack of communication between the partners, and Mr. K's drinking continued. He attended a few A. A. meetings but felt like an "outsider." Apparently, separation was never considered.

The Early Phase of Treatment

When asked why they sought help from the hospital at this time, beyond the matter of Mr. K's sobering up, Mr. K explained that he and his wife had talked it over. She had pointed out that he was not helping himself by continuing the way things were; that he had nothing to lose by giving out-patient treatment a "try." His opinion had been that nothing could help him.

Since his application, I have seen Mr. K for a total of 77 interviews. After 18 months on a weekly basis, these took place with increasing intervals of time between. Mrs. K was seen by a social work student for seven months on a weekly basis for a total of 22 interviews. She chose to terminate them when the student's period of field work ended.

Mr. K recognized from the beginning that the most important aspect of his rehabilitation was maintenance of sobriety. It was rare that we had an interview in which this purpose was not mentioned. To achieve this goal, he sought to overcome tensions and hoped in time to prevent them. Tranquilizers were given under

the supervision of a staff doctor. Mr. K was encouraged to take these in anticipation of situations that might be tension-producing. He was told to eat whenever he felt an urge to drink; to have food easily available. Dieting to reduce weight was discouraged as something to be postponed.

Mr. K's preoccupation with his drinking problem appeared typical. After six months he commented that he used to think of drinking when he was not otherwise occupied; sober, he found there was not enough time for all of his activities. Seven months later he won a case of beer in a raffle. It was tempting to have it in the house; nevertheless, he wanted to keep it to serve to company. When I told him that I would be away for six weeks, he said jokingly that he would not be lonesome—he still had the beer in the basement. I responded rather lightly, as I always did when he teased me about his intention to drink, that I knew he wanted me to worry about him while I was away. When I went on to point out that he had been sober for a year, he reflected, "I had not thought that I could do any better than my father."

Mr. K told me of a frightening dream he had had about drinking, entailing the loss of his job. We talked about the constructive and destructive forces in people and I encouraged him to look at the evidence that in his case the constructive forces were winning. Mr. K theorized that people drink to excess because the amount they are allowed to drink is limited by other persons or by circumstances, usually by one's family. If his body were allowed to become saturated with alcohol the alcoholic would, for once, "have enough" and would stop drinking on his own. Occasionally he asked if I thought he would ever drink again. I stressed the probability that he would always have to keep in mind that he could not drink, but that it would become increasingly easy for him, in all areas, to act constructively in his own behalf.

Husband-Wife Relationships

Early in our work together Mr. K told me that his wife would like him to be the boss but he had not felt free to assume this role while he was drinking. It was not until four months later, however, that Mr. K had enough confidence in his own sobriety to suggest that we work on his relationships with his wife and their

adopted son, Paul. It soon became clear that he viewed himself as a child—to be taught, rewarded, and punished. It irritated him that Mrs. K took no care of her health, complained about her physical condition, and waited for him to tell her what to do. That he could be important to her or that she wanted him to be concerned was a new idea to him. He then paid her more attention, and reported good results, but there were many setbacks. Mrs. K blamed him for her nervousness and he retaliated by hitting back at her in a most sensitive area, commenting on her age. He told me of his longing to communicate with her as with another human being but he found it impossible to reach her except when she was angry.

Mr. K saw his wife as a rough person, and thought she had enjoyed the wild parties that they had had early in their marriage. One can speculate that he remembered his mother as rough and fond of wild parties. When further exploration was attempted, he said, "I would rather not go into that." He said it was only since he had been sober that he had realized with revulsion the kind of person he had married. He took no pleasure in her but thought he might warm up to her if he could overcome his reaction to her hostile and rejecting attitude toward Paul, with whom he identified. Like a little boy, he spoke of being afraid of her rages (perhaps as he had been of his mother's). These fears were always followed by an impulse to drink. At the same time, however, he spoke of a growing "family" feeling; told of how they were now playing cribbage in the evenings and of his offer to help his wife by doing the dishes.

Gradually moving from this childish fear of Mrs. K and these efforts to be a "good boy," he took a fling at adulthood and decided that both she and Paul needed discipline from him. When he announced this decision, I encouraged him to take more responsibility in the household, particularly in the management of their money. Threatened by the prospect of displacing the "mother figure" (his wife), he was unable to move ahead in this direction, explaining that if he did she might also want him to take over the grocery shopping.

For several years Mr. and Mrs. K had slept in separate bedrooms. Now, Mrs. K asked him to sit on her bed before they went to sleep; they would hold hands and read. Mr. K was pleased but

too fearful of rejection to have initiated this. They were now talking about getting twin beds in the same room.

Mr. K came one day for his interview angry and upset. He had a theory that alcoholics need therapy because they are apt to lose control of themselves. Paul usually had a boiled egg for breakfast and, on this particular morning Mrs. K had insisted that he eat a fried egg, which Paul had refused. Mr. K had spanked him with a strap. Following this incident, Mr. K had an urge to drink. It became clear to him that he and his wife used Paul as a scapegoat to act out their aggressions toward each other.

He began to think more about what he wanted in a wife, and decided that he wanted friendliness, not service. As an example, he spoke of her having his breakfast ready when he came downstairs in the mornings, and of her sitting in the car, waiting to take him to work, while he was still eating. She was not a companion; she was a manager.

A month later, he told of romping with Paul in the living-room and of their stopping when they heard Mrs. K on the steps. When asked about it, he answered that he always thought of her as the "typical stepmother." Again, he resisted efforts to associate Mrs. K with figures in his early life. When there was an episode in which he concealed from Mrs. K that he had received extra money, I told him that Mrs. K was not his mother. He grinned and said it was funny that I should mention it—that he often thought of her as his mother. When they went to an art exhibit where Mrs. K's paintings were shown, he observed she was freer than before in her use of color, but he still saw her as a withholding person.

During their vacation, at the end of two years of sobriety on the part of Mr. K, they went on a day trip to a nearby beach. "It was like a second honeymoon," was Mr. K's comment. By then he was able sheepishly to admit that Mrs. K was lonely and he was trying to find ways of their doing things together. He saw his role more as that of an adult, responsible for creating a cheerful atmosphere.

Progress in Achieving Maturity

Perhaps Mr. K's greatest sense of achievement, in addition to sobriety, came from the progress he made in building a relationship with Paul. In the beginning, Paul had been "only a boy" about

whom there was nothing to say. After three months of treatment Mr. K asked for specific suggestions in helping Paul to be less nervous and to make more progress in school. He wanted Paul to have the things he had not had and was ambitious for him to go to college. He especially wanted Paul to have "guidance" from him. When he learned that Paul was to repeat the first grade, Mr. K "took over" and he began by making his first visit to the school. At about this time he successfully disagreed with Mrs. K and with me on specific points in the handling of Paul. These were victories for Mr. K, illustrating his competence as a father. In a way, he matured along with Paul. He observed that Paul responded well when he was included in family decisions and that he did not hold grudges when disciplined; both these attitudes Mr. K began to incorporate as his own.

He subsequently reported another new principle, discovered in dealing with Paul, that had to do with understanding as part of an adult relationship. When they were fishing together Paul had got his line tangled. It suddenly came to Mr. K that he should help him untangle the line and not scold him. As Mr. K expressed it, this incident "opened up a whole new world for me." Now he could take a "reasoning" attitude both with himself and with others.

As has already been indicated, Mr. K was unable to talk much about his early life. He had no pleasant memories of his childhood; when he was lying in bed all he could recall was the picture of his parents, drunk. His only specific memory of his mother was of her hitting him on the head with a baseball bat. His family had never had a Christmas tree or exchanged gifts. He wished there were a man at his office whom he could look up to and copy. His first pleasant memory was of a girl in high school. She was married now, but he occasionally drove by her house, hoping to get a glimpse of her. Apparently feeling guilty, he seemed relieved when I told him I was glad he had had someone to love.

Happily, there now were experiences in Mr. K's everyday life which contributed much to his building of self-confidence. In the very beginning of treatment, he went to a wake and was remarkably strengthened by the fact that he was not teased when he ordered a soft drink. Later, he was put on the nominating committee of his union. He attended an open meeting of the school committee where he was well accepted. Interest in reading stood him in good

stead. He expressed a feeling that he had been dead for twenty years and wanted to read about everything that had happened "in between." He was admitted to a fraternal organization where he had to take vows, thereby proving that people had confidence in him. Very recently he had been elected president of his local union.

In his relationship with me, Mr. K exhibited a kind of shyness and embarrassment, usually quite evident in the beginning of the interviews and disappearing after we got started on the material at hand. On the whole, he viewed the casework experience as an educational one. As we have seen, he identified me as his "teacher." Since we know that he did well in school, we can assume that he got along reasonably well with his teachers and that this was a good and constructive kind of transference for him. He asked for, expected, and received from me a good deal of information and "guidance," as he liked to call it. He spoke of termination as the time when he would "graduate." He identified with me and was in some competition with me.

Mr. K first tried out his new adult role by "lecturing" those around him. He read books on psychology which we discussed. When his wife brought me a plant he lectured me on how to give it proper care. Later, he had enough confidence to ask me to mail a letter for him. His growing maturity was further demonstrated when the frequency of his appointments was reduced and he volunteered to increase his fee on the basis that he could afford more since he would be coming less often. At Christmas during his first and second years of treatment he and his wife together gave me personal gifts. At the third Christmas he more appropriately gave a gift of cash to the hospital.

The casework methods used in helping Mr. K are obvious ones. Recognizing his respect for intelligence and education, I made use of this characteristic in providing an atmosphere for his acceptance of my suggestions and "guidance." In an over-all sense, I think one can say that this has been ego-supportive therapy without clarification or the giving of insight. Mr. K's comments such as "This is too deep for me," or "I would rather not go into that," were fully respected. I tested him from time to time and, on a few occasions, pointed out to him that, if we could go more deeply into some of his earlier relationships, we might be more helpful to him, particu-

larly in understanding his relationship with his wife. But he chose not to do this. Perhaps the only point of clarification was the time I told him that Mrs. K was not his mother.

The Role of Mrs. K

If we look at the family through the eyes of Mrs. K, we get a picture that makes clear the difference between the ways in which he identified the two of us; that is, I was his teacher, but she was his mother. She described him as markedly dependent on her and saw her role as that of his manager and protector, a role which she resented but one in which she could feel some success.

Mrs. K's interviews began with her expression of feeling obliged to suggest things for Mr. K to do to fill up his time. She thought it was too bad that he had only her with whom to talk. She was smart enough to tell when he was going to drink because he would bring up grudges he had against her. She complained of his inability to drink socially; it limited her social life.

Mrs. K bragged about how well she could handle the budget and made fun of Mr. K's childish economies. She pointed out ways in which she had taken care of him—protected him "as a mother does a child." His demands made her nervous. "He misses his mother." He had taken devoted care of his mother during her illness, like a "doctor's apprentice." He had been easy-going with his mother and had handed over his money to her. On the other hand, Mrs. K saw him as resentful of having to do this and said that he held "pet peeves, like a little boy."

Three months after beginning casework interviews, Mrs. K reported in amazement that Mr. K seemed to be changing. He was taking an interest in the house and was more considerate of her. His outlook was now even happier than hers. He was bright and cheerful in the mornings, while it took her two hours to feel human. He was surpassing her in many ways. Later, she expressed anxiety that she was not going to be able to keep up with Mr. K's changes; she feared he would find things too monotonous at home. He was noticing her more; his observations were keener. Like a teacher, he picked her up on nearly everything she said or did; he kept her more on her toes. Further resistance was seen in her complaint of the expense of keeping Mr. K sober; she referred particularly to the cost of materials for a carpentry course.

But Mrs. K had responded well to the interest of her caseworker, explaining that because of having to keep up prestige she could not discuss family problems with her friends. She reported that she was sleeping better and that she was paying more attention to her appearance. After seven months she said that she could take Mr. K's criticism of her better and could tolerate more of his incessant talking and his efforts to improve her. He seemed to be making more sense than he had earlier. She thought he also was better able to take the previously upsetting remarks that she made to him.

Throughout the contact, Mrs. K flatly refused to discuss with the worker her marked feelings of anxiety about her mother's death from cancer and her own hysterectomy, although it was known that she worried much about her health. No pressure was put on Mrs. K to open up areas in which she was resistant. She was given abundance of emotional support as to her own worth, so that she could more easily give up her accustomed role of managing Mr. K. The worker was an appreciative audience for her daily concerns and for her achievement in her portrait painting. Thus, she was helped in modifying her anxiety as the "balance of power" shifted and Mr. K began to get well.

Conclusion

A few general comments based on my clinical experience with alcoholic families may be appropriate. It seems to me that the social worker's casework skills are useful to the alcoholic, and that we can continue to improve them by accepting for casework service those families whose prognosis for rehabilitation is relatively good, such as the K family.

There is an advantage in working within a specialized setting such as the Washingtonian Hospital where, by the very nature of the agency, focus has to be placed on the drinking problem. Social workers in general hospitals or in other types of agencies have to be mindful of the alcoholic's tendency to avoid focusing on the drinking as his primary problem. Our hospital has the further advantage that help is available for medical management of the urge to drink. The use of tranquilizers was an important physical and psychological aid to Mr. K in his ability to give up the use of alcohol, particularly in the early stages. I doubt that in the beginning he could

have held onto sobriety without them. Social workers in non-medical settings would do well to develop medical resources for collaborative treatment of their alcoholic clients, since there is great risk of losing the client if this aspect of treatment is left solely to his own initiative.

Alcoholics are found among members of our society who have matured to varying levels of functioning and who have varying capacities for insight. On the other hand, I should like to stress the point that the alcoholic who cannot tolerate a more thorough understanding of himself may, nevertheless, be rehabilitated; that it behooves social workers to be sensitive to the level at which the alcoholic family can view its problems, and to set methods and goals accordingly.

CURRENT DEVELOPMENTS IN HOSPITAL SERVICE AND THEIR SIGNIFICANCE FOR MEDICAL SOCIAL WORK

Milton I. Roemer, M.D.

THE MODERN HOSPITAL is a major force for helping medicine to fulfil its social obligations. Dr. Henry Sigerist was fond of saying that medicine is a social science and that every physician is ultimately a social worker. His point, of course, was that the goal of medicine is social—to return the patient to social usefulness and, in more recent decades, to prevent sickness and social disability. Yet we know that, acting alone in a private office, the physician is hard pressed to fulfil this role. Organized efforts in many different spheres are required. Among the most important of these efforts —perhaps the most pervasive today—is the complex of services in the general hospital.

It is obvious that the general hospital is undergoing rapid changes in its structure and functions. The innovations are, in my view, due as much to the changing structure of society as to the advancing technology of medicine. And in these organizational adjustments of the hospital to social processes, the social worker plays a key part and can often be a catalyst toward the most positive administrative actions.

One can define the changes characterizing modern hospital service along different lines, but I see them in terms of five movements: (1) economic support, (2) internal administration, (3) therapeutic regimes, (4) attitudes to patients, and (5) community relationships. The forces in each of these channels are affecting the role of the medical social worker directly or indirectly.

Economic Support

Perhaps the most important social movement shaping modern hospital service is *the vast extension of collective economic support,* through insurance and public revenues. In Europe and elsewhere, this movement occurred some time ago but in the United States, after about a century of financial support mainly by private individuals, general hospital financing has again become predominantly social. We are now in the midst of various storms involved in this economic process, with winds blowing wildly among Blue Cross, consumer organizations, insurance companies, state agencies, and hospitals; there is no question, however, about the general direction in which we are going.

This economic movement has several important implications for medical social work. First of all, the basic strengthening of hospital finances has made possible a great enrichment of hospital service. In its simplest terms, this means many more hospital personnel, including medical social workers. The increase in hospital posts has been not only absolute, but has also been relative to the growth of population and, more important, relative to the volume of patients. Thirty years ago about one person in seventeen was hospitalized each year, and he was served by a staff ratio of about one hospital employee per patient. Today, about one person in eight is hospitalized each year, and he is served by a staff ratio of over two employees per patient. Among other things, this development has meant many more positions to be filled in medical social service, even though there may be more staff competition for each dollar in the budget.

Another implication of the extended social financing of hospital care is the change it has fostered in the functional role of the social worker. It is no historical accident that medical social work is one of the few uniquely American contributions to social medicine. We know that the means test was certainly not the inspiration from which medical social work arose in Boston at the opening of the 20th century. But it is equally certain that the growth of the idea throughout the United States in the following years has been associated with the administrative needs of privately financed hospitals to determine the paying-power of their patients. Social workers

have doubtless never enjoyed the task of applying the means test, and with the maturation of the profession they have come to look upon it as more and more onerous and irrelevant to their objectives.

The point is that the widened social base of hospital financing has increasingly relieved social workers of this task, and has freed them more and more to render positive services to patients. At the same time, it has put upon social work the obligation of selling its wares to hospital administration in terms of pure patient-care, without the sugarcoating of giving aid to the business office. That medical social workers have been succeeding in this selling job is proved by the data we shall note later.

A third implication of the broadened financing of hospital service is in the type of patient brought forward for medical social service. There are still plenty of poor families in America, but their proportion as indigent patients on the hospital wards has obviously declined. The medical schools are worried about the loss of—if I may be excused for the horrible expression—"teaching material." Almost every hospital case is some doctor's private patient. But the solution for medical education is also the opportunity for social work, that is, to work with private patients. As one medical educator has said, the only difference is that the student has to learn not only how to diagnose the patient but also how to show him respect. Social service departments, like that at the Boston Beth Israel Hospital, have been developing new approaches to the needs of private patients. The over-all effect, of course, is to cast the social worker as a colleague of the medical and nursing staffs in the care of all patients in a hospital, not just those on the public wards or in the public clinics.

Internal Administration

A second major movement in American hospital service today is *the increasingly systematic administration and organization.* The hospital is no longer a casual, easy-going place, run like the corner grocery. It is an elaborate complex of personnel and equipment, geared to bring a diversity of technical and supportive services to patients twenty-four hours a day. Some of us may nostalgically regret these changes, but the technological clock can hardly be

turned back. Administrators are being formally trained in seventeen university graduate programs, the first of which was started only twenty-five years ago. There are a dozen or more distinct departments in the average hospital—many more in large ones—and the organization chart shows staff and line functions suggestive of a large corporation or a good-sized government agency.

Matching the administrative complexity is a steadily increasing organization of the hospital's medical staff. The modern hospital is no longer just a private doctor's workshop where, as in the South American "mercado," each solo entrepreneur brings his wares for private sale. Instead, the medical staff is organized into specialty services, with a hierarchy of chiefs and committees, each member having privileges and limitations. There are medical-staff by-laws governing what physicians may or shall do in the hospital. There are mandatory consultations in certain types of cases, and the results of therapy are reviewed by colleagues. There are more and more full-time physicians under contract for specified services in the hospital, not only in radiology and pathology—fields associated with much current administrative controversy—but also in medicine, surgery, and other clinical fields. With their heightened teaching responsibilities, hospitals are engaging full-time directors of medical education. More and more systematic research, both clinical and laboratory, is being conducted under hospital auspices.

What relevance does all this have for medical social work? I think that this heightened internal organization of the general hospital creates a setting in which the services of the medical social worker are more appreciated and, at the same time, more needed. In a well organized hospital, social service can be planfully called on and not left to the vagaries of decision-making by different practitioners of uneven sophistication. It can be built into the system, and used whenever objectively required. At the same time, the social worker's particular skills are all the more needed in the complex medical institution, where there is always the danger of the individual's being lost in the shuffle. The professional nurse, of course, also has this duty within the hospital walls, but the social worker is the specialist par excellence in recognizing over-all social and psychological needs and finding ways of meeting them. Modern hospital organization

puts the social worker in a stronger position to play this role.[1] I wish we had time to discuss *how* social work can be most effectively blended into the hospital staff structure.

Therapeutic Regimes

The third change characterizing American hospital service is in *the types of therapeutic regimes* being required for an increasing proportion of patients. I am not thinking of the antibiotic drugs or the surgical use of artificial kidneys; these are, in a sense, only improvements on past methods of medication or surgery. I have in mind the vastly increased importance today of the patient with chronic illness, and all the new modalities of therapy which this has necessitated.

About one quarter of the days of care in general hospitals is now being spent by patients with illness sufficiently chronic to require hospitalization for a month or more. This proportion is rising, and there is no question that the prevention of infection and the aging of the population will make the general hospital of the future as much a place for persons with chronic as with acute illnesses.

Hospitals are responding to this changed patient composition in a variety of ways, all of which have significance for medical social work. Some hospitals are developing special wings or departments for long-term patients, places where the total life needs of these persons can be met better than on a general service with short-term cases. Some hospitals are developing organized home-care programs, by which the skills of the hospital staff are brought to the chronic patient in his own home, thus making the hospital bed available to another case. Many hospitals are developing strong rehabilitation departments to hasten the recovery of patients with acute and chronic illness alike. General hospitals here and there are developing working relationships with nursing homes and homes for the aged to assure better medical care for residents of these institutions. Then, there is the great experiment under way on so-called "progressive patient care," by which the clinical departments of a hos-

[1] J. A. Rosenkrantz, M.D., and P. F. Luchesi, M.D., "The Medical Social Worker: Keystone of the Comprehensive Medical Care Program," *Hospital Management*, Vol. LXXXV, No. 5 (1958), pp. 58–59.

pital are categorized according to the degree of the patient's disability and his length of stay, rather than the diagnosis of the case.[2]

Each of these therapeutic regimes for long-term patients involves a special need for medical social service. Chronic illness, more than acute illness, requires for its proper management the use of a wide variety of community resources. The medical social worker is obviously the best person on the hospital team to bridge the space between the hospital bed, the patient's home, and the complex world of organized health and welfare services. He is certainly the person best equipped to deal with such resources as public welfare, vocational rehabilitation, disability insurance, voluntary health societies, industrial employers, senior citizen centers, nursing homes, family service agencies, housing authorities—with all the hundred and one organized resources which can in some degree help families cope with long-term illness.

Despite the variety of these public and voluntary programs for chronic illness, medical social workers must know better than others how much they fall short of meeting needs. It is for this reason that so many of us look forward to the time when the hospital and medical-care needs of older persons will be effectively financed under the nation-wide social security system. Although debates on the Forand Bill and similar measures have been hot and heavy, there can be no doubt that some such legislative action will soon be taken. And then, the opportunity of the medical social worker to help the patient with long-term illness will be greater than ever.

Attitudes to Patients

Despite the increasing complexity and, as some might say, impersonality of the modern hospital, a fourth movement has other significance for social work. I refer to *a growing attitude of sensitivity* to the total needs of patients.

It is not so great a paradox as it may seem to suggest that hospitals are becoming more institutionalized and more patient-centered at the same time. A great deal of the enlargement of staff and the more elaborate equipment of the modern hospital is directed essen-

[2] "Report on Progressive Care—It Works," *Modern Hospital,* Vol. XC, No. 5 (1958), pp. 73–78.

tially toward meeting the most intimate personal needs of sick people. The norms today call for more nursing time per patient per day, for visiting hours that are more flexible, food that is more appetizing, and furnishings that are more home-like. With private-duty nursing disappearing in the face of heightened demands for full-time staff nurses, hospitals now have special "recovery rooms" where every post-operative patient receives intensive nursing service as a hospital routine. The fact that *Look* magazine and the *Ladies Home Journal* can publish articles on how people are pushed around in hospitals is really evidence of the level of sensitivity to patients that is today regarded as only reasonable. Such exposés were not published thirty years ago, when conditions were far poorer, simply because people did not expect so much.

A patient-centered approach is also expressed in methods of medical education. Training medical students through "comprehensive care" programs has become fashionable, and the young physician is well indoctrinated with the viewpoint of psychosomatic medicine. Another expression of this attitude is the opening of general hospital beds to psychiatric patients and the increased liaison between general hospitals and mental hospitals. Many hospital out-patient departments are also changing their character; the benches are being replaced with chairs, appointments are being made, and private patients are being welcomed for certain services.

All these changes in institutional attitudes toward patients create a milieu, it seems to me, in which the skills of social work must be better appreciated. I do not mean to suggest that every hospital would score high on an ideal measure of patient-centered service, but its score would be higher than it would have been twenty years ago, and the importance of such service has become a recognized value. With such conceptions as the norm, the necessity of qualified social service in every hospital is becoming more and more recognized by administrators, hospital boards, and physicians. In this stress-conscious society of ours, the challenges presented to the medical social worker are all the greater.

Community Relations

Finally, there is *a growing network of relationships* between the general hospital and other organizations, which has important implications for medical social service. No longer is the hospital an

isolated haven for the poor and the lonely. Seventy-five per cent or more of its patients are beneficiaries of some insurance plan or public agency. Among the latter—departments of public welfare, workmen's compensation boards, veterans or military agencies, vocational rehabilitation divisions—there are many relationships to be maintained on matters other than the payment of the hospital bill. Interchanges are also increasing between two or more hospitals near each other in a region. The regionalization idea is being promoted, steadily if not rapidly, by hospital associations and councils. A variety of informal working relationships have evolved among hospitals for specific diagnostic, treatment, or administrative service.[3]

The hospital has been evolving slowly into a community health center. Doctors' offices are being established within or adjacent to the hospital buildings. Here and there, a group practice clinic is closely affiliated with a hospital. Health departments, in a slowly growing number of jurisdictions, are being tied to general hospitals physically, if not administratively. Relationships with nursing homes and other long-stay institutions have been mentioned previously. Great medical centers, combining facilities for tuberculosis and mental disorder, rehabilitation programs, organized home care, and polyclinics are growing up around virtually every one of the nation's seventy-five medical schools, and elsewhere as well.

In the maintenance of many aspects of these inter-agency relationships, the social worker is a specialist. More than any other hospital worker, perhaps, he is or can be a minister of external affairs. The more the hospital must fulfil its goals through ties to other agencies, the more the medical social worker will have to do.

Conclusion

This completes a very sketchy account of the principal current developments in hospital service that seem to me to have special significance for medical social work. I shall conclude with some thoughts on how these many challenges might be met.

We know that there are not nearly enough medical social workers in the United States to fill the positions now open in general hospitals, let alone the new positions that ought to be established. The

[3] M. I. Roemer, M.D., and R. C. Morris, "Hospital Regionalization in Perspective," *Public Health Reports*, Vol. LXXIV, No. 10 (1959), pp. 916–922.

joint study made by the National Association of Social Workers, the American Hospital Association, and the U. S. Public Health Service, in 1956, showed this clearly. Although no one seemed willing to state an optimal numerical standard, everyone agreed that the existence of social work staff in only 13 per cent of short-term general hospitals represented a severe shortage—especially when the understaffing of many of the covered institutions was considered.[4]

The shortage is greatest, of course, in the small hospitals. Yet, I venture to say that every hospital, however small, should be provided with *some* medical social service. Study of the latest (1958) American Hospital Association data, in fact, shows a slight improvement in social work staffing of the small hospitals since 1953, but the proportion covered is still only about 5 per cent of facilities with fewer than 100 beds.

To serve the social service needs of patients in these small hospitals requires not only a larger over-all supply of medical social workers, but also imaginative types of co-ordination. When I was working in western Canada, we developed a regional hospital program through which one social worker served thirteen small hospitals in a thinly settled territory of 50,000 population. She was based at the central hospital and traveled around the region. Another approach might be to have in smaller towns an all-purpose social worker, who could share time between the hospital, a family service agency, and perhaps a health department or public welfare agency.

Such combined efforts would, at best, represent an expedient, and the soundest planning would surely place a full-time medical social worker in every hospital of 50 beds or more. (With transportation at its present level, moreover, there should be need for few hospitals of smaller than 50-bed capacity.) Proper use of social work skills, in my opinion, should involve a social screening of virtually every hospital patient—no less than the screening routines now accepted in the way of a blood count or a chest X-ray. The majority of patients may need no assistance with personal problems, but the social worker is in the best position to identify those patients who

[4] *Social Work in Hospitals,* Public Health Service Publication No. 519, U. S. Government Printing Office, Washington, D. C., 1957.

do, or who might need it later on. As aged and chronically ill patients come to occupy an increasing share of hospital beds, the positive yield of such routine case reviews would rise. The development of such a social screening procedure offers a challenge to the social work field.

From my reading of the medical social work literature in recent years, I trust that such a proposal may not seem as outlandish as it would have seemed twenty years ago, when Rule Number One required that social work help should never be offered unless it was asked for.[5] I am not sure how widely a more aggressive community-oriented approach to social work is accepted today or how much it may be concentrated among social workers attached to public health agencies, welfare departments and other public programs. In any case, social resources are so complex today, and the stresses on the individual are so subtle and manifold, that the need for social and psychological aid is tremendous—far greater, I would say, than either patients or physicians ever voluntarily request. Unlike doctors, moreover, few medical social workers are in private fee-for-service practice, so that a positive approach to the needs of patients could hardly be condemned as unethical solicitation of business.

To cope with the many problems emerging from current hospital trends, then, requires not only more social workers, more aggressive policies in the hospital, but also, I think, a steady focus on the community as well as the individual client. I have not discussed the role of the social worker in the diagnostic work-up of hospital cases, in rooting out psychological problems obstructing individual patient-care, in advising the physician on the feasibility of certain regimes of treatment, and so on. These subjects get plenty of attention. The larger challenges today, in my view, face the social worker as a specialist in community problems and community resources. In these spheres, he can meet urgent needs not met by others. And, in so doing, he can play a central role in helping the hospital to fulfil its widest social responsibilities.

[5] Elizabeth P. Rice, "Medical Social Work—A Current Statement," *Medical Social Work*, Vol. IV, No. 4 (1955), pp. 127–143.

THE CONCEPT OF AUTHORITY AND SOCIAL CASEWORK

Samuel Mencher, D.S.W.

AUTHORITY IS LOOKED UPON as a phenomenon alien to our culture. Although authority is present in almost every situation in which social interaction occurs, Americans in general, and particularly social workers, tend to deny its existence. In reality, authority plays a part in all casework relationships. Yet social workers, consciously or unconsciously, have avoided recognizing its presence. The scanty casework literature dealing with the concept of authority,[1] the relegation of the use of authority solely to the protective and correctional services, the questioning of the appropriateness of casework in these situations, and even the relatively recent development of "aggressive" casework—all are indicative of the caseworker's resistance to the phenomenon of authority.

This resistance is not peculiar to caseworkers. From its earliest beginnings, American society has been suspicious of any leanings toward authority. For example, although the individualistic and unilateral idea of the social contract had been abandoned in Europe by the end of the 18th century, it has continued to influence American life and is the foundation of the controversy about states' rights.[2] In social work, emphasis on the independence and self-determination of the client has led to either an underestimation of

[1] Elliot Studt has made significant contributions in this area. For example, see "An Outline for Study of Social Authority Factors in Casework," *Social Casework*, Vol. XXXV, No. 6 (1954), pp. 231–238, and "Worker-Client Authority Relationships in Social Work," *Social Work*, Vol. IV, No. 1 (1959), pp. 18–28.

[2] J. W. Gough, *The Social Contract*, 2d ed. The Clarendon Press, Oxford, 1957, Chapter XIV.

the effect of social controls on human behavior or a refusal to recognize that situations requiring control may come within the scope of social work practice. The author of a recent professional article has pointed to the variety of factors that modify the acceptance of self-determination as the "supreme" or decisive value in the social work process.[3] Although much of the literature on social psychology and administrative theory in relation to both small and large group systems is devoted to the function of authority, in casework practice authority has only managed to intrude itself into what have been considered special or atypical fields of practice.[4]

The Meaning of Authority

What is authority? If we set aside our prejudices, we are forced to recognize that authority and power have much in common. Some prefer to consider that authority is founded on the democratic acceptance of legitimacy, and that power is dependent on supports external to the relationships it influences.[5] Thus the terms "leadership" and "headmanship" are used to differentiate two types of control—the democratic and the authoritarian. However, although the manner of control is important for understanding the specific application of authority, the source of control does not in itself change the basic nature of the phenomenon.

Authority may be broadly defined as the power to induce changes in, or to exert control over, the behavior of another. Its influence is dependent upon how it is perceived or accepted by those to whom it is directed. Thus, as Chester I. Barnard says, "Authority . . . lies with the persons to whom it is addressed, and does not reside in 'persons of authority.' "[6] It is the willingness to be influenced, whatever the origin of the willingness, that determines the authority or power. In effect, authority can only be recognized by its effects on the person who accepts it—the acceptor. It is in the perception of the acceptor that authority comes into existence.

[3] Saul Bernstein, "Self-determination: King or Citizen in the Realm of Values?" *Social Work*, Vol. V, No. 1 (1960), pp. 3–8.

[4] I should like to thank Professor Werner A. Lutz for his critical reading of the present article in manuscript.

[5] Carl J. Friedrich, "Authority, Reason, and Discretion," *Authority*, Carl J. Friedrich (ed.), Harvard University Press, Cambridge, 1958.

[6] Chester I. Barnard, "A Definition of Authority," *Reader in Bureaucracy*, Robert K. Merton *et al.* (eds.), The Free Press, Glencoe, Illinois, 1952, pp. 180–185.

The origin of the word authority—*augere,* to augment—offers a useful clue to the function of authority. Authority comes into play when the individual who is being influenced accepts proposals of which he is not fully convinced. In effect, authority increases or lends strength. When a person is fully convinced of the logic of the proposals offered, he is no longer reacting to the *agent* of authority but rather to the *impersonal authority* of ideas. When he demands a convincing and rational explanation of the proposals, he is no longer accepting the authority of the agent. Thus, authority may be redefined as *the acceptance of the influence or control of another beyond what the individual or group would normally do or would do merely through the exchange of ideas.* John R. P. French, Jr. and Bertram Raven refer to this exchange of ideas, or "informational power," as follows:

> If this impersonal acceptance of the truth of the fact is independent of the more or less enduring relationship between O and P, then P's acceptance of the fact is not an actualization of expert power. Thus we may distinguish between expert power based on the credibility of O and the informational influence which is based on characteristics of the stimulus such as the logic of the argument or the 'self evident' facts.[7]

As has already been indicated, authority is a common phenomenon of social interaction. Thibaut and Kelley state: "If two persons interact, the pattern of outcomes given in their interaction matrix indicates that each person has the possibility of affecting the other's reward-cost positions and, thereby, of influencing or controlling him." [8] In other words, all human relationships have a gratification-frustration potential which affects the behavior of the participants. We may thus assume that in every social work situation there are elements of authority. Like the phenomenon of transference, authority may flow back and forth between the participants. The old static concept of authority has been superseded. We now realize that authority or leadership is situationally determined, and the follower and leader roles are interchangeable. Even in casework practice, there are times when the client influences or

[7] French and Raven, "The Basis of Social Power," *Studies in Social Power,* Dorwin Cartwright, (ed.), University of Michigan Institute for Social Research, Ann Arbor, 1959, pp. 163–164.

[8] John W. Thibaut and Harold H. Kelley, *The Social Psychology of Groups,* John Wiley and Sons, New York, 1959, p. 100.

controls the worker and, in effect, the worker accepts the authority of the client.

The existence of authority cannot be denied, and successful treatment of the client requires that it be understood and handled effectively. The appropriate use of authority can be an important tool in all casework. In some cases it may be the pivotal factor through which casework goals are achieved. The use of authority can be what Lippitt calls the "leverage point" or "the starting point" in the helping process. In using authority, however, the worker should be aware of Lippitt's principle that, "There must be at least a possible line of change progress from the leverage point to the change objective." [9] Exerting authority is not an end in itself in casework, although the client's acceptance of authority may be one of the goals. Eventual change in the kinds and range of authority to which the client responds may define, however, the "line of change progress."

Authority is not a simple phenomenon. Several types of authority may be delineated, and each has its own potentialities for influencing change. For example, some types of authority may effect only superficial change in the acceptor, while others may have deeper and more lasting consequences. Some may involve side effects such as aggression and hostility; others may stimulate greater co-operation and socialization. Since the impact of authority is dependent on the climate of acceptance, the effectiveness of any authority is related to the "reward-cost" equation for those accepting the authority relationship. In order to have stability, the relationship must provide the acceptor with satisfactions superior to those he perceives as "his best available alternative to the present relationship." [10] In a coercive setting such as a prison, some may find the cost of accepting authority higher than the expected rewards of leaving the system or escaping, even considering the low probability of a successful "outcome." Obviously, in most casework situations the variety of alternative relationships is greater, and it is easier for the client to secure them. The authority agent, in this instance the caseworker, must consider the competing alternatives available to the client.

[9] Ronald Lippitt, Jeanne Watson, Bruce Westley, *The Dynamics of Planned Change*, Harcourt, Brace, New York, 1958, p. 102.
[10] John W. Thibaut and Harold H. Kelley, *op. cit.*, p. 100.

Types of Authority Relationships

There are five major types of authority relationships, each of which has a particular potential for affecting behavior. It is the *acceptor's perception* of the source of the agent's authority that characterizes each type. Thus, the acceptor perceives the authority agent in one or more of the following ways: (1) the agent is able to provide rewards; (2) the agent is able to coerce him or to provide punishments; (3) the agent represents an appropriate reference figure; (4) the agent possesses special wisdom or expertness; and (5) the agent has the legitimate right to regulate the acceptor's behavior.[11] In actual practice the same agent may be perceived as possessing more than one type of authority. Moreover, an authority relationship that originates in one perception may evolve into a different type of relationship. Each of these types of authority relationship will be briefly discussed.

1. In an authority relationship based on the acceptor's perception of the agent as possessing the power to reward, the acceptor tends to "monitor" his own behavior so that he can prove to the authority agent his right to be rewarded. Reward authority may lead to the acceptor's internalizing the agent's standards and identifying with the agent as a reference authority (type 3). This potentiality is greater when the agent's attractiveness to the acceptor is increased through the provision of actual rewards.

It is obvious that an authority relationship based on reward can be an important influence for change in casework. As a "leverage point," it has the advantage of involving perceptions of a less socialized nature than do relationships based on reference, expertness, or legitimacy. The acceptor is reacting initially to the concrete gains available rather than to the personal attributes of the authority agent. When compared to coercion or punishment authority, reward authority has much greater possibilities for moving the acceptor toward the more socialized types of authority dependent on internalized norms.

Reward authority, to a greater extent perhaps than the other types of authority, requires that the agent have actual control over external sources of satisfaction. Studies made by the University

[11] These five bases of authority follow generally the typology of John R. P. French, Jr. and Bertram Raven, *op. cit.*, pp. 155–164.

of Michigan Survey Research Center have shown that the worker's satisfaction with the authority of the supervisor in industry is dependent upon the supervisor's influence with the larger organization beyond his particular unit. Through this influence, the supervisor is able to facilitate the workers' achievement of their goals. Similarly, one may hypothesize that if the caseworker is to be perceived by the client as a reward agent, he must be able to influence the external structure through which rewards may be mediated for the benefit of the client. For example, the school social worker must have enough influence over sources of satisfaction meaningful to the child that the latter sees the worker as a person who can provide rewards that are greater than the costs to him of accepting the norms of the school culture.

Discretionary power like the ability to facilitate the achievement of goals, is pertinent to all types of authority. Having authority entails "the exercise of discretionary power." For example, from the school's point of view, the school social worker is vested with legitimate authority arising from the public nature of the institution. The child or his parents may not perceive the worker's authority from this point of view. As the possessor of legitimate authority, the worker must be vested by the organization with sufficient flexibility or discretion to use this legitimate authority constructively.[12]

2. Coercive authority, based on the assumed capacity of the agent to punish, is allied with the negative power of withdrawing satisfactions. Its effect is to encourage the acceptor's superficial or observable conformity. This type of authority relationship frequently leads to conflict in the acceptor between his internal or private responses and his need to display in public only the expected behavior. The agent must maintain careful oversight over the acceptor's behavior because the acceptor is motivated to avoid contact with the authority agent rather than bring himself to the agent's attention. Rather than being a source for identification, the agent becomes the focus of the acceptor's fear, frustration, and hostility. Because coercive authority emphasizes the costs of accepting authority to the exclusion of its rewards, it tends to increase the acceptor's desire to withdraw and seek alternative relationships.

[12] See Carl J. Friedrich, *op. cit.*, p. 45.

Thus, coercive authority may be most successful in such systems as prisons where the acceptor has few alternative choices. Where there is the possibility of developing other types of authority relationships, coercive authority may operate as the "leverage point" for needed emergency action. The goal, however, is to move the acceptor toward relationships that have greater potential for positive change.

3. Caseworkers are probably most familiar with referent authority —authority based on identification with the agent. The agent has great attraction for the acceptor, and the greater the attraction, the wider the range of influence. Some therapists who work with delinquents have suggested that the therapist assume certain characteristics valued by the delinquent in order to establish the basis for referent authority. In general, referent authority does not emphasize observable or public conformity. It permits more integrated behavior on the part of the acceptor, and the changes effected may quickly become incorporated in the acceptor's behavior pattern.

4. Expert authority, or the acceptor's perception of the agent as a person with special knowledge or wisdom, is a type of authority relationship more common in casework than social workers seem to recognize. For whatever the reason, whether it be our own insecurity, our perception of our public image, or our confusion of expert authority with authoritarianism, we avoid recognizing the extent to which expert authority is present in all professional situations. We would all agree that a physician, a lawyer, or an engineer who had little confidence in his own expertness would not offer us the most satisfactory professional relationship. Moreover, we are able to distinguish clearly between the physician whose expertness gives him authority, and the physician whose overbearingness makes him authoritarian. Our confidence in the former is based on our belief that he is acting within the range of his own expertness and that he can give rational explanations for his own practice. Our distrust of the latter is based on his frequently not meeting either of these criteria. Expert authority is inherent in professional practice, and the social worker who tries to deny this aspect of his professional role is, in effect, avoiding full professional responsibility.

5. Finally, legitimate authority is derived from the acceptor's perception that the agent has the right to determine, within the range of his authority, the acceptor's behavior. In most casework

situations that are currently acknowledged to require "authority," legitimate authority is involved; and the client's ability to accept legitimate authority is the goal most frequently set. When one speaks of the child who cannot accept authority, he is usually referring to this kind of authority. Legitimate authority relies on internalized standards—the presence of a code that establishes for both the agent and the acceptor the legitimate basis of the former's authority and the latter's acceptance. Legitimate authority thus tends to be impersonal; it relies less on the personal qualifications of the agent than upon the accepted legitimacy of his function. However, despite the fact that a legitimate authority relationship has a formal basis, legitimacy increases the acceptability of the agent.

Using Authority Constructively

Whatever the perceived source of authority—reward, coercion, reference, expertness, or legitimacy—and the variations in the effects of each, authority itself engenders reactions in the client which must be recognized if it is to be used constructively in casework. On the positive side, authority offers the client the satisfaction of being able to identify with and incorporate the strong person. Research on the functioning of small groups has demonstrated that laissez-faire leadership neither stimulates productivity nor is satisfactory to the members.[13] On the negative side, however, authority may foster dependency and reawaken fantasies of the "magic helper." Authority poses for the acceptor a conflict between his drives toward independence and his dependency needs, and the agent becomes the focus of these ambivalent attitudes. As suggested above, the source of the agent's authority may serve to mitigate or to strengthen this conflict, but the conflict probably exists to some degree in all authority situations. This is particularly true in those casework situations in which the use of authority is a strategic element in the casework process. It is in these situations that the types of authority brought into play involve the greatest conflict for the client. In many instances, both standardized norms of behavior and acceptable reference groups are lacking, and the client does not respect legit-

[13] Ralph White and Ronald Lippitt, "Leader Behavior and Member Reactions in Three 'Social Climates,'" *Group Dynamics*, Dorwin Cartwright and Alvin Zander (eds.), Row, Peterson and Co., Evanston, 1953, p. 610.

imate standards of control or the conventional symbols of wisdom and expertness. Hence, he perceives authority as determined by authoritarian rather than democratic controls.

The authority agent, in this instance the caseworker, must employ his diagnostic skill in using authority. Essential to a diagnosis of the authority relationship is the worker's recognition that the client's dependence-independence conflict is increased by his insecurity. His insecurity may be lessened if he is able to understand the worker's communications, is able to comply with the worker's expectations, believes that the worker's expectations are compatible with his own personal interests and with those of the groups whose membership he values, and if the agent's expectations are consistent.[14] I should like briefly to emphasize the last point—consistency of expectation.

Consistency of expectation on the part of the worker reduces the arbitrary nature of the power of the worker in the eyes of the client. He is less insecure because he does not have to respond to the vagaries of ill-defined demands. "Even without making incorrect behavioral choices, [the acceptor] may worry about the possibility of doing so, and this tends to raise his costs for all the activities involved." [15] If the manner of control is "standardized," the situation becomes predictable and, in effect, the client is less dependent on the personal influence of the worker and more dependent on his own ability to control his behavior. This is particularly true for the poorly adjusted client. Organizational research has found that "structured normative procedures are preferred to more informal and spontaneous ones by low-power members"; poor producers—less effective members—are more "vulnerable," and they "experience less anxiety about their vulnerability if there are structured procedures to protect them from managerial power." [16]

When a consistent relationship between the worker and client is established, whatever the perceived source of the worker's authority, the client's anxiety, arising from uncertainty and subordination to a personal symbol of authority, is reduced. The relationship then produces more constructive results. The client can gradually be encouraged to identify with the demands, expectations, and needs

[14] See Chapter I, Chester I. Barnard, *op. cit.*, p. 181.
[15] John W. Thibaut and Harold H. Kelley, *op. cit.*, p. 131.
[16] *Ibid*, p. 132.

of larger groups such as the family, the community, or the school, outside the direct worker-client relationship.

Consistency of expectation, however, does not imply that authority is used rigidly. The worker must guard against the situation in which the client believes, whether correctly or not, that he cannot influence the outcome. All of us are familiar with the child who maintains that, no matter what he does, his parent or teacher punishes him. This child is saying that he is struggling against external controls, albeit consistent, which he cannot influence. Little satisfaction can be obtained from responding to authority under these circumstances. Here, again, the worker's diagnostic skill and the amount of discretionary power permitted him come into play. If the demands of the institution, whether it be a school or another organization, are so rigid that the worker cannot use some discretion, many expectations will be beyond the capacity of the client. Moreover, the client will not have the satisfaction of obtaining various rewards in payment for his conformity to expectations. When the demands of authority are beyond his comprehension or his capacity to meet them, the client is helpless. Under some circumstances he may respond passively; under others, he may reject the authority entirely because the cost to him is so much out of keeping with the anticipated rewards. In such circumstances the worker must have sufficient influence in the organization to be able to offer rewards commensurate with the client's capacity to meet the demands made on him.

Influencing Client Behavior

I should like to emphasize again that authority arises from the volition of the acceptor rather than from the intrinsic control of the agent. As has been reiterated throughout this paper, it is the perception of the acceptor that, in the final analysis, determines the existence of authority. The agent must recognize that no matter how broad the base of the authority delegated to him by the acceptor, there are always limits to the influence of any authority relationship. In casework, for example, it is appropriate for the client to respond overtly or covertly to a worker's question by asking "Why should I answer this question?" or more directly "What right have you to ask this question?" The client may well feel, however,

that the members of his family or his close friends have a relatively unlimited right to show interest in his affairs.

If the worker is to use constructively the authority elements in the casework relationship, he must be aware of the limits of his authority as determined by the client's perception. Barnard, one of the pioneers in organizational theory, introduces the term "zone of indifference" to identify that area within which each individual is willing to accept controls "without conscious questioning." [17] There are two other areas: a zone of neutrality in which the acceptor makes decisions as to whether he will or will not be influenced; and a zone of unacceptability in which he refuses to recognize the influence of the agent or, more exactly, fails to perceive the authority of the agent.

Obviously, the most fruitful zone for affecting the behavior of the client is the "zone of indifference" where the worker's influence is considered clearly appropriate to his function. However, the worker's goal of bringing about change in the client's behavior may require that the worker have a greater range of influence than the client is willing to recognize at the outset. This situation frequently arises when formal institutions, such as the school, are involved, since it is the client's unwillingness to accept the normal or legitimate authority of the school that may bring him into conflict with society. The worker's task is then one of broadening the range of authority acceptable to the client. The worker must first find the client's "zone of indifference" and then develop a treatment plan that will extend the range of authority acceptable to the client. Clues for achieving the treatment goal can be found in understanding the various types of authority and their specific effects.

If authority is an essential element in the treatment plan, the worker's greatest chance of success lies in broadening the client's "zone of indifference" rather than threatening the total relationship through expecting too much of the client before he is ready to accept authority. Authority is a tenuous phenomenon, and the total casework relationship can be threatened when the worker makes demands that are out of keeping with the client's expectations and that result in the client's denying authority. As stated so well by Barnard in his discussion of organizational authority:

[17] Chester I. Barnard, *op. cit.*, pp. 182–184.

There is no principle of executive conduct better established in good organization than that orders will not be issued that cannot or will not be obeyed. Executives and most persons of experience who have thought about it know that to do so destroys authority, discipline, and morale. This principle cannot ordinarily be formally admitted, or at least cannot be professed. When it appears necessary to issue orders which are initially or apparently unacceptable, either careful preliminary education, or persuasive efforts, or the prior offering of effective inducements will be made, so that the issue will not be raised, the denial of authority will not occur, and orders will be obeyed. It is generally recognized that those who least understand this fact—newly appointed minor or "first line" executives—are often guilty of "disorganizing" their groups for this reason, as do experienced executives who lose self-control or become unbalanced by a delusion of power or for some other reason. Inexperienced persons take literally the current notions of authority and are then said "not to know how to use authority" or "to abuse authority." Their superiors often profess the same beliefs about authority in the abstract, but their successful practice is easily observed to be inconsistent with their professions.[18]

Summary

1. Authority has been viewed as a phenomenon common to all social interaction in which the behavior of one person may be influenced by that of another.

2. The use of authority is an inherent aspect of social work practice and is determined by the perception of the person who accepts the control. It is this acceptance that endows the worker's expectations with additional strength or power and defines his authority.

3. The perceived sources of authority vary. The agent of authority may be endowed with additional influence because he is perceived as possessing the capacity to reward, coerce, or provide special expertness; as having characteristics with which the acceptor seeks to identify, or as representing legitimately delegated responsibilities. Each of these sources of authority has specific potentialities for affecting behavior.

4. Authority, whatever its perceived source, engenders tension, which may be reduced by consistency of expectations.

5. The use of authority is determined by the capacity of the acceptor, his goals, and the clarity and range of the agent's expectations.

6. The caseworker as an agent of authority must recognize the capacity of the client, the basis upon which the client vests him with authority, and the range of authority the client attributes to him. Through his relationship with the client, he may move the client

[18] *Ibid*, pp. 182–183.

toward accepting more constructive bases for authority, thus broadening the range of the client's acceptance of authority.

7. To facilitate a successful outcome for the client, the caseworker must have sufficient power of discretion delegated to him by the institution in which he operates.

8. The use of authority is a constructive element in all types of casework. It is not a factor that operates only in special or punitive relationships.

ISSUES INVOLVED IN DEVELOPING DIAGNOSTIC CLASSIFICATIONS FOR CASEWORK

Samuel Finestone

As THE SOCIAL WORK LITERATURE increasingly deals with questions of theory and research, discussions of the need to develop diagnostic classifications multiply.[1] The discussants point to many values that would accrue from such typologies. The rationale is as follows: (1) Systematic theory building will be stimulated; (2) social work concepts and propositions will be formulated in ways that will provide a basis for research; (3) social work teaching will become more effective because of the availability of organized content; (4) academic and field teaching can be more effectively co-ordinated; (5) the use of knowledge from other disciplines will be facilitated; (6) the contribution of social work knowledge to other disciplines will be facilitated; and (7) ultimately, social work practice will be made more effective.

In addition to discussions about the need for typologies, the literature also contains reports of some actual classification schemes. Some schemes which are implicit in expositions on the nature of

[1] Dorothy Fahs Beck, "Research Relevant to Casework Treatment of Children, I. Current Research and Study Projects," *Social Casework*, Vol. XXXIX, Nos. 2–3 (1958), pp. 106–107; Werner W. Boehm, *The Social Casework Method in Social Work Education, Vol. X., A Project Report of the Curriculum Study*, Council on Social Work Education, New York, 1959; Ernest Greenwood, "Social Science and Social Work: A Theory of Their Relationship," *Social Science Review*, Vol. XXIX, No. 1 (1955), p. 28; Gordon Hearn, *Theory Building in Social Work*, University of Toronto Press, Toronto, 1959; Alfred J. Kahn, "Sociology and Social Work: Challenge and Invitation," *Social Problems*, Vol. IV, No. 3 (1957), pp. 220–228.

social casework are general and broad.[2] A number of others are more structured and specific. The group includes a typology for forms of family adaptation; [3] a problem classification for a medical social work setting; [4] a combined diagnostic and treatment classification for social casework; [5] and a parallel diagnostic and treatment classification for social work as a whole.[6] The most rigorous scheme is a problem classification for social casework developed as part of a research study related to continuance in casework treatment.[7]

A third trend in the literature, which is relatively new, consists of reports of the examination of methodological and conceptual issues involved in constructing a classification scheme. One example is a student group project [8] and another is an article by Selby.[9]

In general, the literature leaves one with the impression that the rationale for diagnostic classifications has been convincingly presented, but that consideration of the methodological and conceptual issues involved in their construction have just begun.

The Concept of Classification

The use of the term "classification", when applied to social casework, should be clarified. It is used in two ways. The first refers

[2] Eleanor E. Cockerill, Louis J. Lehrman, Patricia Sacks, Isabel Stamm, *A Conceptual Framework for Social Casework*, University of Pittsburgh, 1953; Community Service Society, *Statement on Social Casework Practice*, New York, 1957, (mimeographed); Florence Hollis, "The Nature of Personality Change in Social Casework," Address delivered at National Conference of Social Work, May 1956, (unpublished); Henry S. Maas, "Social Casework," *Concepts and Methods of Social Work*, Walter A. Friedlander (ed.), Prentice-Hall, Englewood Cliffs, N.J., 1958, pp. 15–115; Helen Harris Perlman, *Social Casework: A Problem-Solving Process*, University of Chicago Press, Chicago, 1957.

[3] Nathan W. Ackerman, M.D., *The Psychodynamics of Family Life*, Basic Books, New York, 1958, p. 329.

[4] Elwin Barett, *et al.* (Faculty Supervisor Margaret Schubert), "Problem Classification in a Medical Social Work Setting," Student Project, School of Social Welfare, University of California at Berkeley, June, 1959.

[5] Louis J. Lehrman, *Science, Art and Social Casework*, Pittsburgh, 1957, (mimeographed).

[6] Olive M. Stone, *Problem Solving in Dalton*, Council on Social Work Education, New York, 1959.

[7] Lilian Ripple and Ernestina Alexander, "Motivation, Capacity, and Opportunity as Related to the Use of Casework Service: Nature of Client's Problem," *Social Service Review*, Vol. XXX, No. 1 (1956), pp. 38–54.

[8] Timothy Aller, *et al.* (Faculty Supervisor Kermit T. Wiltse), "Classification for Social Work Problems," Student Project, School of Social Welfare, University of California at Berkeley, June, 1958.

[9] Lola G. Selby, "Typologies for Caseworkers: Some Considerations and Problems," *Social Service Review*, Vol. XXXII, No. 4 (1958), pp. 341–349.

to the task of constructing a scheme of diagnostic categories to which units can be assigned. It is this meaning with which this paper is concerned. The second use of the term refers to the process of assigning a unit to a given class or category. In research, this operation is termed coding, or categorizing.

In actual practice, caseworkers engage to some degree in a categorizing of cases. They see that a complex situation is similar in significant respects to other situations. However, their mental activity in such categorizing may be carried on without their full awareness of the process. It, therefore, cannot be easily checked. Since there is no formal classification scheme in which a situation can be categorized, the process remains an informal one, carried out on an "intuitive" basis. The construction of explicit, logically thought-out, and empirically-tested classification systems would provide a means to relate situations to each other in a systematic way. Such schemes would also be a means of making the components of the process explicit and, thereby, strengthen the scientific basis of casework practice.

The Concept of Diagnosis

Assumptions about the nature of casework diagnosis crucially affect a diagnostic classification. The literature reflects the different conceptions about diagnosis that are held in the field. The classification constructor, obviously, needs to make choices among these conceptions and their implications.

Some authors place primary emphasis on what the client wants help with, while others emphasize the worker's appraisal of the client's need. My own opinion is that the latter view includes the former, and that this approach is the only one fully consistent with the purpose of diagnosis. One reason for this position is that there are large numbers of clients who are not able, without a great deal of assistance over a considerable period of time, to know what they want help with. Space does not permit a discussion of the issues but they obviously need to be resolved.

Our notions about the purpose of diagnosis determine to a large extent the way we define it. There appears to be wide agreement that the purpose of diagnosis is to guide treatment efforts through suggesting the content focus, the goals, and the methods

of treatment. From this point of view, diagnosis includes not only the location and description of the problems on which treatment is to be focused, but also some formulation of their cause. A treatment-oriented view of "cause" is implied in the sense that we are concerned with factors which determine client difficulties and which are alterable by casework treatment. This notion is different from a view of cause which includes *all* determinants of difficulty and ultimate levels of causation, and which is not formulated in terms of treatment. Rather "cause" is considered to signify effective determinants of difficulty, effective for change purposes. Researchers will recognize that this formulation concentrates on "action" variables.

The conception of effective determinants does not imply that a history of the client's past and present is unnecessary. A full exploration may be required before it is possible to select a level of causation that points the way to an appropriate treatment focus.

In summary, it would seem that diagnosis includes: (1) the *location* of the difficulty, that is, where it is manifested; (2) the *description* of the difficulty, that is, how it is manifested; (3) the *effective determinants* of difficulty, that is, what are the elements in the client and his environment that are maintaining the difficulty and are susceptible to change; and (4) *the assets for change,* that is, what resources in the person and environment can be enlisted for change.

Knowledge of the location of a difficulty is useful for a limited, but valuable, kind of problem counting. If both the location and description of a difficulty are taken into account, a fuller picture is available and these data may be useful for certain kinds of research. If, in addition, the effective determinants of difficulty and the assets for change are taken into account, an adequate basis for treatment planning becomes available. With knowledge of all four factors, it becomes possible to infer the necessary components of treatment—goals, content, and method.

It is evident that a distinction should be made between the terms "problem" and "diagnosis." The problem comprises the location and description of the difficulty. Diagnosis, a more comprehensive concept, includes not only the problem but also the effective determinant of the problem, and the assets available for its modification.

This discussion of diagnosis, which is neither comprehensive nor definitive, is presented in order to underscore the problem of con-

structing a classification scheme. Any person attempting to develop a scheme must arrive at some explicit ideas about the nature of diagnosis.

Decision Points in Constructing a Classification Scheme

Purpose

Any attempt at classification construction involves a series of interrelated decisions. First, it is necessary to clarify the purpose of the proposed classification. Why is the classification scheme being constructed? The answer to this question influences a number of other decisions. Four possible reasons for constructing a diagnostic classification in social casework may be identified: (1) to clarify an exposition on practice; (2) to report service statistics; (3) to carry on research involving some concept of need or problem or diagnostic category; and (4) to provide a systematic basis for decisions about treatment.

No one of these purposes is any more laudable than any other, but the purpose should be clear. If the purpose is to report service statistics, a gross location of problem may be appropriate. Such a classification system, however, must be a comprehensive one with clearly defined and mutually exclusive categories. If the purpose is to investigate specific research questions or test specific hypotheses, more variables, and more complex variables, will be required. The number and complexity of the variables, however, may need to be limited. For example, Ripple and Alexander [10] have studied the relationship between certain variables (capacity, motivation, and opportunity) on the one hand and continuance in casework on the other, in which the nature of the problem was taken into account. In such a study, if the breakdown of the problem involves too many separate categories, a statistical analysis is not feasible unless a large sample is used.

The fourth purpose, which is the chief concern of this paper, is that of constructing a diagnostic typology that would assist caseworkers in making appropriate decisions in treatment. For this purpose, the diagnostic classification system—which must be elaborated and made specific to a considerable degree—must parallel

[10] Lilian Ripple and Ernestina Alexander, *op. cit.*

a matching treatment classification system. Such co-ordination between diagnostic and treatment classifications would serve as a safeguard against considering either diagnosis or treatment in isolation from each other.

This concept of a classification plan has several implications for research. First, that the construction can logically start from either the diagnostic or treatment end and shuttle back and forth. Second, that if each class of the diagnostic typology is matched with its co-ordinate class in the treatment typology, a series of hypotheses suitable for research testing is generated. The hypotheses would take the following general form: a particular combination of treatment measures, when applied to a given psychosocial diagnostic syndrome, will lead to the desired results more often than the use of other treatment measures. Finally, such a linking of diagnostic and treatment classifications implies that the research would be within the framework of *practice theory*. It would not be based only on behavioral theory and it would not consist merely of an ad hoc listing of treatment procedures.

The Domain to Be Classified

After clarifying the purpose of a classification scheme, the constructor must face the problem of defining the *domain* with which he wishes to deal. What are the boundaries of the phenomena that are to be classified?

One decision that must be made pertains to the level of abstraction of the proposed plan. Theoretically, it is possible to construct a classification scheme that would be applicable to all healing professions. Hearn has proposed theory building at this level, using such "general system" concepts as input, output, self-regulation, feedback, and the like.[11] Somewhat less generalized, but still at a high level of abstraction, are attempts at classification for social work as a whole. Drawing on an anthropological frame of reference, Stone has proposed a classification of broad life tasks as an approach to diagnostic typology. The categories in this classification are viewed as applicable to social casework, group work, and community organization.[12]

[11] Gordon Hearn, *op. cit.*
[12] Olive M. Stone, *op. cit.*

Coming one step farther down the ladder of abstraction, we reach the level of practice methods within social work. Such efforts at classification have been made in casework, but the writer does not know of any similar attempts in group work or community organization. The principles would be much the same for all methods, since it can be assumed that all social work operations are directed toward desired changes in some undesirable "state of affairs." These "states" must be classified and linked to appropriate treatment methods. This paper will be focused on social casework classifications; the points discussed, however, have relevance to other social work methods.

Lehrman's attempt to formulate a typology for casework is particularly interesting, since he links psychosocial diagnostic categories to treatment categories.[13] Another example of a casework typology is the classification of problems developed by Ripple and Alexander.[14] Their approach differs from Lehrman's in that they engaged in a specific research project which required operational definitions and reliability testing. Although both of these classification schemes have implications for treatment, caseworkers would have difficulty in applying them since the broad domain of practice is covered by relatively few classes.

Even more specific are classifications of practice clusters in particular casework settings, such as medical social work and family casework. In a student group project under the leadership of Schubert, a problem classification was developed for a medical social work setting, and the problems were related to the type of service given.[15]

Most specifically related to practice are classifications of problem areas within settings. For example, family casework settings deal with marital problems, as well as other problem areas. Classifications within these problem areas are often found in the clinical literature. While these classifications are frequently richly insightful, and therefore helpful to the practitioner, they are often fragmentary, and have logical and theoretical weaknesses.

Theoretically, it is possible to combine various levels of abstraction in one master classification scheme; categories in a lower level

[13] Louis J. Lehrman, *op. cit.*
[14] Lilian Ripple and Ernestina Alexander, *op. cit.*
[15] Elwin Barett, *et al.*, *op. cit.*

scheme become subcategories in the next higher one. The possibility of accomplishing the task, however, is remote, since a master scheme is dependent on a unified theoretical frame of reference: theory would need to be linked to specifics of practice in every field and setting of social work.

Practically, however, the question to be answered is: At what level or levels of abstraction is it most fruitful to concentrate effort? It seems to me that the key to the answer may be found in an attempt to link theoretical generalities to specifics of practice. I believe that logical and useful classifications may emerge if one moves back and forth between the specific problem areas, such as marital or child-parent, and social casework as a whole. This approach would not produce a single diagnostic typology for all of casework but a series of specific typologies for the various problem areas. Some of the problem areas (such as refusal of necessary surgery) would be specific to a setting, while others would be found in a variety of settings. The typology developed for the various problem areas, however, would be influenced by concepts common to social casework as a whole.

The full reasoning behind my choice of such an approach can be only briefly outlined. It is an approach that combines middle- and low-range levels of abstraction. I believe it offers possibilities for empirical practice to affect theoretical formulations, and vice versa. At this stage in the development of social work, attempts to engage in classification at higher levels of abstraction might be satisfying philosophically and aesthetically but they are not likely to be effective, since the links between theory and practice are so remote and tenuous.

The Scope of Social Casework

If social casework is selected as the level for classification, a first requirement is definition of its scope. The classification constructor must either make a choice of definitions from among those found in the literature, or develop a formulation by an empirical analysis of practice. Or he may combine the two approaches. Whatever his approach, inevitably he takes a position, if only by implication.

Some discussants of the nature of social work consider that the

enhancement of the social functioning of individuals is the focus of casework effort,[16] while others extend the definition to include personal fulfilment. The literature also reveals the varying degrees of emphasis that caseworkers place on the concrete needs of people, as well as their different ways of conceptualizing them. Some authors consider that the meeting of a client's concrete needs is necessary to his individual fulfilment and is, therefore, a primary concern of casework. Others consider a client's lack of material resources as a factor related to defective problem-solving capacity, defective role performance, or emotional deprivation.

Conceptions about the boundaries of casework treatment vary in other ways. Some formulations emphasize the current problem of the client and his rational and conscious psychological processes. Others emphasize the need to understand irrational behavior and deal with preconscious material. A recent monograph describes how the caseworker helped clients gain insight into previously unconscious wishes.[17]

The classification constructor will have to find some core of agreement that exists within casework and some position in relation to differences.

The Unit of Classification

After a decision about the *domain* of casework has been made, the classification constructor must specify the *units* to be classified. Which units, within the domain, are to be classified? We may say that we are classifying cases, but this answer begs the question. We are still left with the problem of defining a case.

When the focus of diagnosis and treatment is on one person, the "indivdual" is the appropriate unit of classification. This is true, even if the influence of others in the family is taken into consideration since the caseworker treats the problem from the viewpoint of the individual. Often, however, treatment is focused on a family pair, such as mother and child, or husband and wife. The pair may be understood as a unit, and treated as such. In these instances, the classification constructor needs to think in other ways

[16] Werner W. Boehm, "The Social Work Curriculum Study and Its Implications for Family Casework," *Social Casework*, Vol. XL, No. 8 (1959), pp. 428–436.

[17] Beatrice Simcox Reiner and Irving Kaufman, M.D., *Character Disorders in Parents of Delinquents*, Family Service Association of America, New York, 1959.

than in terms of the traditional "individual" problem, since an interacting dyad is the unit of attention.

A still more complex unit is the family as a whole. The concept of "family diagnosis," which implies understanding the family as an interacting unit, presents many difficulties to the classification constructor. Ackerman has offered a broad classification of family functioning, implying that it may be viewed from two perspectives: the way the family regulates its internal relationships and the way the family as a unit adapts to the external environment.[18]

In an effort to avoid making a dichotomy of person and environment, of separating the psychological and the social, Reid has proposed a classification plan for casework treatment based on a communication network. His idea is that a person in trouble and all those in significant communication with him should be conceived and treated as a unit.[19]

The pioneering effort to formulate interactional units of attention are stimulating and provocative, but they present complex problems to the classification constructor. The classification constructor may need to select the unit of attention that seems most feasible and significant, recognizing that there are other approaches. It seems likely that different units of attention require different kinds of diagnostic treatment classifications.

The Theoretical Model Underlying Classification

The issues discussed above all hinge on a larger one, that is, the selection of the theoretical model that is to underly the classification plan. No classification system can be built without some concepts and propositions, whether explicit or implicit, systematic or unsystematic, or loosely or precisely defined.

A diagnostic classification is based on the selection of significant distinctions between cases; these distinctions are important since they influence the goal, content, and technique of treatment. In analyzing a "case," it therefore is necessary to select, from an enormous amount of information, a number of items that are considered to be significant. But how are we able to select these significant items?

[18] Nathan W. Ackerman, M.D., *op. cit.*

[19] William Reid, *Classification of Treatment Methods in Casework: Developing a Conceptual Framework for Casework Research*, March 1960, mimeographed, dissertation proposal, New York School of Social Work, Columbia University.

The answer to this question will be determined by our theoretical notions.

These theoretical notions, which include a variety of concepts, enable us to name and describe certain phenomena, and to classify them under major headings with subheadings. The phenomena in the various classes and sub-classes differ from each other in certain ways, but they have a relationship to each other since they stem from a central concept. For instance, in social casework, a central concept which has been proposed by many persons is that of enhancing the social functioning of individuals. Our theoretical notions also include propositions about internal and external forces presumed to affect social functioning. More concretely, we believe that certain biological and psychological forces within persons, and environmental forces outside them, affect their social functioning in particular ways. In addition, we have a number of notions about the ways in which we can modify the forces affecting the social functioning of individuals, and also about what constitutes adequate or inadequate social functioning. Since modification implies change in a desired direction, value premises are closely linked with treatment principles.

In general, then, it may be said that casework diagnostic classifications express and formalize notions about the social functioning of persons, identify the internal and external forces that affect it, and point to ways of modifying it. A classification system, therefore, cannot be any better than existing theory. Since many casework concepts and assumptions have not yet been precisely formulated, let alone tested, the classification task presents a rather gloomy outlook. There are, however, some hopeful signs, such as the current interest in theory building in the total field of social work. Concepts and assumptions are becoming more explicit, greater use is being made of knowledge from the behavioral sciences, and practice research is yielding new findings.

Classification itself is a form of theory building. In the process of classification construction, it is necessary to explicate assumptions and to refine and systematize them; it is also necessary to identify gaps and issues in current knowledge and to point the way to the further development or reformulation of theory. In a sense, classification construction is getting down to brass tacks about theory.

Ego Psychology and Role Theory

Two main theoretical systems regarding the nature of social casework are receiving current attention. The first, ego psychology, has been in the forefront for several years,[20] and the second, role theory, has emerged more recently.[21] Since the classification constructor will need to use these theories as sources of concepts, it seems pertinent to comment briefly on them and on their interrelationships. A first question to be considered is whether two or more theoretical systems can be used in a classification scheme, or whether an all-embracing one is required. At present, neither theoretical system is sufficiently developed, let alone validated, to provide adequate underpinning. It seems to me that an attempt to establish a single all-encompassing theoretical base would demand that data be forced into the Procrustean bed of a particular orientation.

The concepts of ego psychology seem to me to have much relevance to the problem of classifying cases. Since ego functions are both integrative (internal management) and adaptive (management of relations between person and environment), ego psychology covers both personality organization and its relationship to the environment. Although the concept of ego-adaptive patterns is useful in making distinctions between various individuals, it is not helpful in making distinctions between various kinds of social interaction or environmental situations. Also, in focusing on adaptive patterns, biological factors may be overlooked. It should be noted that ego psychology cannot be fully understood except as part of a broader set of concepts comprised in personality theory.

Role theory is strong where ego theory is weak. It offers possibilities for making useful distinctions between types of social interactions but offers little help in making distinctions between personality types. These two theories, therefore, may be considered to complement each other rather than to be in opposition. At certain points, there is a convergence of the two theories. Social functioning viewed from the vantage point of personality theory has

[20] Annette Garrett, "Modern Casework: The Contributions of Ego Psychology," *Ego Psychology and Dynamic Casework*, Howard J. Parad (ed.), Family Service Association of America, New York, 1958, pp. 38–52; Isabel L. Stamm, "Ego Psychology in the Emerging Theoretical Base of Casework," *Issues in American Social Work*, Alfred J. Kahn (ed.), Columbia University Press, New York, 1959, pp. 80–109.

[21] Werner W. Boehm, *op. cit.*; Henry S. Maas, *op. cit.*

much in common with role performance viewed from the vantage point of role theory. It should be noted, in passing, that role theory does not encompass all aspects of the environment, notably the physical aspects.

One sociologist puts the relationship of personality theory and role theory in relation to social functioning (role performance) in the following way: "Without in any way challenging the crucial importance of the objective factors which determine role behavior, I wish to stress that recruitment into roles and the quality of role performance may to an important degree be influenced by personal qualities in individuals which predispose them to move toward one or another role, and which have a marked effect on the quality of their role performance once they have been placed." [22]

Role theory, because of its origins in sociology, has certain biases which should be kept in mind. Role theory tends to emphasize achievement and the task-oriented aspects of social functioning, and to place little emphasis on the "expressive" or emotional aspects. It emphasizes the rational and objective elements that determine ineffective role performance rather than the irrational and subjective elements in the personality. Adequacy of role performance tends to be measured in terms of social norms rather than in terms of the needs of the individual. Obviously, one could also set up a list of biases inherent in ego psychology.

It would seem that concepts of both ego psychology and role therapy might be utilized in the proposed dimensions of diagnostic classification; that is, the location of difficulty, the description of difficulty, the effective determinants of difficulty, and the assets for change. If the enhancement of social functioning is accepted as the focus of casework, role theory seems especially useful in revealing where the client's difficulty is manifested. If individual fulfilment—a more psychological orientation—is considered the focus, role theory alone will not suffice for the location of the difficulty.

Both role theory and ego psychology are useful in *describing* difficulty. Descriptions of ego-adaptive modes of behavior and role-performance patterns have much in common and may point similarly to social functioning or dysfunctioning. Both theories, too,

[22] Alex Inkeles, "Personality and Social Structure," *Sociology Today*, Robert K. Merton, Leonard Broom, Leonard S. Cottrell, Jr. (eds.), Basic Books, New York, 1959, p. 262.

illuminate the determinants of difficulty, as well as the assets that can be utilized to bring about change; subjective and objective elements in dysfunctioning can be assessed by concepts drawn from both theories.

It should be stressed that in developing a classification plan, biological factors in the individual as well as physical factors in the environment would need to be given special consideration, since neither ego psychology nor role theory emphasizes these elements.

Methodology of Classification Construction

There are a number of ways to approach the construction of a classification plan. The methods are not alternative, since the results of one tend to complement those of the other. A sequence of study phases might be designed as part of an over-all research program. The study might begin with a phase of particular interest to the researcher, but there should be an interweaving of theoretical and empirical investigations.

Some persons might choose to begin with an "armchair" phase. In this phase, the researcher makes a critical review of existing theory, and engages in "mental experimentation" with possible models. By logical processes of thought, he postulates categories that fall within these models. Although this kind of activity is essential, it is likely to produce a one-sided picture. If the person does not check his formulations against existing practice, he is likely to be seduced by his own ideas and, in consequence, omit important elements that do not easily fit into his framework.

At the opposite extreme, some investigators engage in a minimum of *a priori* theorizing and begin by developing categories from raw data. In such instances, the research method used would be some variant of content analysis. One student of content analysis has called attention to the risks involved in this approach.

> Simply going on a fishing expedition through some common communication material is almost certain to be unrewarding. Unless there is a sensible, or clever, or sound, or revealing, or unusual, or important notion underlying the analysis, it is not worth going through the rigor of the procedure, especially when it is so arduous and so costly of effort.[28]

The value of switching back and forth between empirical data

[28] Bernard R. Berelson, *Content Analysis in Communication Research*, The Free Press, Glencoe, Illinois, 1952, p. 198.

and *a priori* theoretical categories, until both concrete applicability and generality are achieved, is stressed in an important discussion of classification construction.[24] Such an approach in efforts to develop classification schemes implies that the relevant literature and research reports be systematically reviewed and critically appraised. Existing diagnostic classifications, whether formal or informal, should certainly be studied. One way to carry on a conceptual analysis of existing classifications has been described in the social research literature.[25]

The operations involved in developing a classification scheme may be listed as follows:

1. Identification of the distinctions implicit in the classification.
2. Conceptualizing the distinctions by formulating dimensions.
3. Defining these dimensions and stating the basic assumptions underlying their choice.
4. Stating additional assumptions and dimensions where these seem indicated.
5. Identifying the sub-categories of each dimension.
6. Reconstructing the original classifications, after considering various possible combinations of the categories in the dimensions.

By analyzing several existing diagnostic schemes, and by using the steps outlined above, I found that four major dimensions—with some minor variations—had been identified: (1) the location of the difficulty; [26] (2) the adequacy of social functioning,[27] or adaptation to stress,[28] or quality of planning; [29] (3) the relative importance of internal and external determinants of social functioning;[30] and (4) the degree of secondary stress arising from impaired functioning.[31]

[24] Paul F. Lazarsfeld and Allen H. Barton, "Qualitative Measurement in the Social Sciences: Classification, Typologies, and Indices," *The Policy Sciences*, Daniel Lerner and Harold D. Lasswell (eds.), Stanford University Press, Stanford, 1951, pp. 155–192.

[25] Allen H. Barton, "The Concept of Property-Space in Social Research," *The Language of Social Research*, Paul Lazarsfeld and Morris Rosenberg (eds.), The Free Press, Glencoe, Illinois, 1955, pp. 40–53.

[26] Elwin Barett, *et al.*, *op. cit.*; Lilian Ripple and Ernestina Alexander, *op. cit.*

[27] Elwin Barett, *et al.*, *op. cit.*

[28] Henry S. Maas, *op. cit.*

[29] Ernest Greenwood, *op. cit.*

[30] Louis J. Lehrman, *op. cit.*; Lilian Ripple and Ernestina Alexander, *op. cit.*

[31] Louis J. Lehrman, *op. cit.*

Although other dimensions might be formulated from the material, it is obvious that the existing classifications provide useful substantive leads for further study. In general, it would seem that the greatest gap exists in the dimensions related to the determinants of social difficulties.

Conclusion

Some of the major issues involved in constructing diagnostic classifications for social casework have been presented, but not all have been covered. A personal point of view has been expressed about some of the issues, but these opinions should be viewed as targets for appraisal rather than final conclusions.

The task of classification construction is a complex one, requiring the efforts of many people over an extended period of time. The nature of the task demands that theory-minded practitioners and practice-oriented theorists combine their research efforts. Some thought might profitably be given to ways of facilitating the communication and exchange of critical reactions between groups working on classification construction in order that the gains may be reciprocal and cumulative. One means might be that of establishing a national committee, under the auspices of a professional association, for the purpose of co-ordinating efforts in classification construction.

The task is a demanding, and in a sense a never-ending, one since any classification system should be thought of as subject to change. Nevertheless, efforts at classification construction may hold rich rewards for our profession.